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ABSTRACT

This report documents the progress made in developing and developed nations to improve health, nutrition, education, family planning, and the condition of women over the last 40 years. It presents tables that rank the world's nations and regions on: (1) the mortality rate of children under 5 years of age; (2) the percent of children under 5 years of age who are malnourished; (3) the percent of children immunized against measles; (4) the percent of children reaching grade 5 in school; (5) the average number of births per woman; and (6) the mortality rate of women due to childbirth complications. The report provides statistics on national performance gaps, the difference of the level of progress achieved and the expected level of progress for each country's gross national product. It also examines the progress made by the world's nations to ratify and implement health, nutrition, and education goals contained in the United Nation's Convention on the Rights of the Child. (MDM)

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THE PROGRESS OF NATIONS

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The nations of the world ranked according to their achievements in health, nutrition, education, family planning, and progress for women

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1993

THE PROGRESS OF NATIONS

The day will come
when the progress of nations will be
judged not by their military or economic
strength, nor by the splendour of
their capital cities and public buildings,
but by the well-being of their peoples:
by their levels of health, nutrition and education;
by their opportunities to earn a fair reward for their
labours; by their ability to participate in the
decisions that affect their lives; by the respect that is
shown for their civil and political liberties;
by the provision that is made for those who are
vulnerable and disadvantaged; and by
the protection that is afforded to the growing minds
and bodies of their children.
The Progress of Nations, to be published annually
by the United Nations Children's Fund, is a
contribution towards that day.

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Newly independent nations

Because comparable data are not yet available, newly independent countries are not adequately represented in this first issue of *The Progress of Nations*. It is hoped that more data on social indicators will be available in time for inclusion in the 1994 edition.

SUB-SAHARAN AFRICA

MIDDLE EAST and NORTH AFRICA

SOUTH ASIA

EAST ASIA and PACIFIC

CENTRAL AMERICA and CARIBBEAN

SOUTH AMERICA

INDUSTRIALIZED COUNTRIES

The Progress of Nations is published by the United Nations Children's Fund (UNICEF) as a contribution to monitoring and improving the well-being of children in all nations. Each year, it will record national achievements in child survival, health, nutrition, education, family planning, and progress for women.

In each of these areas, the international community has set goals which reflect today's new capacity to meet minimum human needs. The governments of 149 countries have formally committed themselves to the achievement of these goals by the end of the century. *The Progress of Nations* will keep track of action and achievement in the fulfilment of these commitments.

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INTRODUCTION

The industrialized world is entering an age of doubt about material progress.

But for a billion people in the world, material progress holds out the hope of adequate food, clean water, safe sanitation, decent housing, reliable health care, and at least a basic education.

This is a definition of progress which remains entirely valid. And it is one with which the rest of the world must keep faith.

Keeping faith with progress

An introduction to *The Progress of Nations*

The industrialized world is entering an age of doubt about material progress. Many of its citizens are experiencing what the economist Robert Heilbroner has called "the startled realization that the quality of life is worsening ... that people who are three or five or ten times richer than their grandparents do not seem to be three or five or ten times happier or more content or more richly developed as human beings." Coinciding with such doubts is the gradual realization that such progress is also no longer limitless, that what was once the clear and infinitely extending horizon of material advance is now becoming closer and darker as ecological limits loom.

But for at least a billion people in the world, material progress has very different connotations. It holds out the hope of adequate food, clean water, safe sanitation, decent housing, reliable health care, and at least a basic education. This is a definition of progress which remains entirely valid. And it is one with which the rest of the world must keep faith.

Disillusionment

In the 1960s and 1970s, hopes rode high that national and international efforts would soon enable all people to meet these needs. But over the last decade, such hopes have been replaced by a widespread disillusionment, a sense that development has not worked, a feeling that the effort to end the worst evils of absolute poverty has been tried and failed.

This perception is wrong on both counts: it has not been tried; and it has not failed.

At a very rough estimate, the governments of the developing countries have been devoting, on average, only about 10% of their annual budgets to nutrition, water supply, primary health care, primary education, and family planning. Similarly, only about 10% of all international aid for development has been specifically devoted to these purposes. This means that many governments of the poor world have been spending less on meeting human needs than on meeting military bills and debt-servicing obligations. And it means that the total amount of aid being given for the specific purpose of meeting these most obvious and basic of human needs is less than the amount that the people of the industrialized world spend each year on sports shoes.

A serious attempt to meet minimum human needs has therefore not yet been made.

Forty years of progress

Yet despite this less than all-out effort, the majority of people in the developing world have progressed to the point at which their minimum needs are being met.

This may come as something of a surprise to many people in the industrialized nations, where information about the developing world comes almost exclusively from news reports of its disasters and appeals for money to meet its needs. But the facts are that in little more than one generation, average real incomes have more than doubled; child death rates have been more than halved; malnutrition rates have been reduced by about 30%; life expectancy has increased by about a third; the proportion of children enrolled in primary school has risen from less than half to more than three quarters; and the percentage of rural families with access to safe water has risen from less than 10% to more than 60%. In the meantime, the proportion of couples using modern contraceptive methods has risen from almost nothing to more than 50% and average family size is now falling in almost every country.

Such statistics hide great failures and great disparities; poverty, oppression, and exploitation are alive and well. But by any realistic standards, the progress made in the last 40 years has been remarkable. And if the task of meeting minimum human needs had been given any real priority over that time, then it would by now have been largely accomplished; we would today be living in a world in which mass hunger, malnutrition, and preventable disease were things of the past, and it is fair to assume that it would also be a world with less civil conflict, slower population growth, and more manageable environmental problems.

The old and the new

There is a clear danger, in the years ahead, that the combination of an unjustified disillusionment with development, and an understandable preoccupation with new challenges, may cause the international community to bestow even more neglect on the issue of basic material progress for its poorest members.

This would be a mistake both in principle and in practice. For a renewed effort to overcome the age-old problem of absolute poverty is essential if the world is to meet the new challenges that lie ahead. As better nutritional health would improve productivity, so it would allow the poor to make economic progress. As education would enable people to participate in political and economic life, so it would foster the democratic process. As primary health care would give people more confidence in the survival of their children, so it would lead to smaller families and slower population growth. And as material progress would ease day-to-day pressures and give the poor a stake in the future, so it would help to protect the environment.

The case for renewed national and international efforts to meet minimum human needs is therefore more compelling than ever as the 20th century draws to a close.

The task is also more achievable than ever before. Advances in knowledge and technology mean that many of the most serious problems could be overcome at relatively low cost. And in recent years, the developing world has built up its infrastructure and communications capacity to the point where it is capable of bringing these advances to virtually all its citizens.

As evidence of this, one need look no further than the rise in immunization levels over recent years.

A decade ago, fewer than 20% of infants in the developing world were being immunized against the major vaccine-preventable diseases. By the mid-1980s, many nations had begun to take seriously the WHO/UNICEF target of 80% immunization by the end of the decade. In the great majority of developing countries, that goal was reached. And the results have been predictably spectacular. Approximately 3 million young lives a year are being saved; unknown millions are being protected from disease-induced malnutrition (see page 15); and approximately 3 million children are growing up normally who would have been crippled by polio were it not for the rise in immunization over the last ten years.

The underlying significance of this achievement is that 80% immunization implies a system of supply, training, management, communications, and delivery, that is capable of getting the right vaccines at the right time and at the right temperature to over 100 million infants a year on four or five separate occasions during their first year of life. However imperfect that system still may be, nothing could more convincingly demonstrate that the developing nations now have the capacity to put the most basic and important benefits of progress at the disposal of almost all of their people.

Political commitment

Advances in knowledge, technology, cost reduction, and outreach capacity are not enough. The political determination to get the job done is also essential, and too often this has been the missing link.

In the case of the immunization achievement, that determination was forged in many different ways. But

In little more than one generation, average real incomes have more than doubled; child death rates have been more than halved; malnutrition rates have been reduced by about 30%; life expectancy has increased by about a third; the proportion of children enrolled in primary school has risen from less than half to more than three quarters; and the percentage of rural families with access to safe water has risen from less than 10% to more than 60%. In the meantime, the proportion of couples using modern contraceptive methods has risen from almost nothing to more than 50%.

THE PROGRESS OF

INTRODUCTION

the common elements were a clear and measurable goal, a public commitment to that goal by political leaders (virtually every president and prime minister in the developing world formally signed a commitment to the immunization goal in the 1980s), and the mobilization not just of health services but of almost every other organized resource – the schools, the mass media, the religious orders, the non-governmental organizations, the business community, and the professional organizations.

Without such a mobilization, goals and targets have often been mere rhetoric, promises made on public platforms, echoing ever more faintly down the years. But with sustained public support, specific social goals can help to catalyse progress: they can serve as a stimulus to long-term effort, as a focal point for management by objectives, as a common aim for all who collaborate in an enterprise, and as a lever for raising public awareness and political pressure.

World Summit

As the 1990s began, it became clear to many that a new potential existed for meeting minimum human needs. Decades of relatively small-scale experiments had shown that child malnutrition could be at least halved by new and affordable approaches, that virtually all of the major childhood diseases could be prevented or treated at very low cost, that new technologies and community-based strategies could make clean water affordable and available to all, and that providing at least a basic education for every child was by no means beyond the bounds of possibility. At the same time, the immunization achievement was showing, in dramatic fashion, that the outreach capacity now existed to make these advances available not just to the few but to the many.

In an attempt to focus attention on this potential, a World Summit for Children was convened at the United Nations in September of 1990. It was attended by a majority of the world's political leaders, and its principal outcome was a commitment to a range of new goals to be achieved by the year 2000. These goals, each one reflecting specific advances and low-cost strategies, include a one-third reduction in under-five mortality rates, a halving of child malnutrition, 90% immunization coverage and control of the major childhood diseases, the eradication of polio, a halving of maternal mortality rates, 80% primary-school completion, the provision of safe water and sanitation for all communities, and the universal availability of family planning services.

In the last three years, 86 governments have drawn up national programmes of action (see pages 46 to 48) to achieve these goals, and these plans are now being put into effect, with varying degrees of commitment and vigour.

What is needed, in all countries, is more depth and breadth of support from opinion leaders and the media, from educators and religious leaders, from the non-governmental organizations and the professional bodies, from the political parties and community organizations, and from the public at large. The goals and the means of achieving them must be articulated and argued for in every country; the proportion of government spending, and of international aid, allocated to the meeting of basic human needs must be doubled to at least 20%; the systems for monitoring progress must be put in place; and the United Nations family must play its part in supporting and monitoring progress towards the goals which have been agreed by almost all its Member States.

Monitoring progress

The Progress of Nations is a UNICEF contribution to this renewed effort to meet minimum human needs. Each year, it will bring together the statistics on the progress being made, in each country, towards basic human goals. For it is time that the standing and prestige of nations was assessed less by their military and economic prowess and more by the protection they provide for the lives, the health, the growth, and the education of their children.

The closer monitoring of social indicators allows nations to see their achievements and rates of progress and to compare them with the record of other nations in a similar geographic region or economic grouping. Internally, monitoring informs policy, introduces accountability, galvanizes and rewards effort, and is a means by which sustained pressure can be brought to bear for the fulfilment of political promises.

All this was recognized in the Plan of Action drawn up at the World Summit for Children. "Each country should establish appropriate mechanisms," states the Plan, "for the regular and timely collection, analysis and publication of data required to monitor relevant social indicators relating to the well-being of children such as neonatal, infant and under-five mortality rates, maternal mortality and fertility rates, nutritional levels, immunization coverage, morbidity rates of diseases of public health importance, school enrolment and achievement and literacy rates."

Statistical weakness

As is repeatedly pointed out in the pages of *The Progress of Nations*, the statistics by which social improvements are measured are inadequate. In all cases, the data used are the most recent and reliable estimates available to the United Nations system. But for too many countries, the available figures for several key indicators – and particularly those concerning child survival and nutrition – are extrapolations derived from mathematical models and regional trends rather than actual figures derived from recent and on-the-ground national surveys or comprehensive vital registration systems.

This lack of data reflects, in part, the lack of development. But with each year that goes by, this weakness reflects less and less a lack of capacity and more and more a lack of priority. Most nations can and do produce quarterly statistics on the health and growth of their economies, but very few produce even annual statistics on the health and growth of their children. The statistics in *The Progress of Nations* are therefore presented, with full acknowledgement of their frailties, as an approximate guide to national achievement and as a challenge to the better measurement of human progress.

As a minimum, all nations should produce annual statistics on basic indicators of social progress – under-five mortality, child malnutrition, primary school completion, adult literacy, and family planning. Statistics on economic growth, on inflation and interest rates, are now used on a regular basis by all serious media and have become part of informed political and public debate in almost all nations. They are one of the principal means by which politicians are held accountable in democratic systems. If progress towards meeting minimum human needs is to be given more priority, then similar use must be made of annual statistics which show what percentages of a nation's children are adequately nourished, or are immunized, or are enrolled in school, or have access to clean water and basic health care.

It is particularly important that improved systems for collecting data on human well-being should be put in place before the World Summit on Social Development in 1995.

Limits to distortion

Despite these problems, available social indicators present a more accurate picture of progress for the majority of a nation's people than per capita GNP – the conventional measure of progress and development. The natural scale does not allow one person to live a thousand times as long as another, even if the man-made scale allows one person to have a thousand times as much income as another. It is therefore more difficult for a wealthy minority to affect the figures for average life expectancy, or the under-five mortality rate, than it is for that minority to affect the figures for per capita GNP.

Despite these limits to distortion, social indicators can and do mask serious disparities. A national immunization level of 75%, for example, can mean that 95% of children are immunized in the cities and 65% in the rural areas. A primary-school completion rate of 80% can mean that 100% of boys are being educated and 60% of girls. An under-five mortality rate of 50 per 1000 can mean a rate of 30 per 1000 for children born into the mainstream of the nation's life and 150 for those born to ethnic minorities, or to the geographically isolated, or to the politically disenfranchised.

If national under-five mortality rates are very high or school completion rates very low, then it is obvious that the problems they reflect are ubiquitous and that action is needed on a broad front. But as rates and averages rise, national social indicators become less sensitive and the measurement of disparity becomes a more important guide to action. When under-five mortality rates fall to low levels and immunization coverage rises above 80%, for example, then it becomes important to focus more and more on the disparities, to find out how many fall below the average and by how far, to identify who and where they are, and to know why they are being marginalized by progress. At this stage, the monitoring of disparities can be a means of achieving one of development's most difficult tasks – the task of reaching out to the unreached, to the poorest women, to the minorities and the geographically remote, to the despised and discriminated against, to the illiterate and the unconfident.

Symptom and cause

The social goals that have been adopted by the international community amount to a programme to meet minimum human needs and, in particular, to protect children from the worst effects of poverty.

The placing of children at the centre of this process, and of *The Progress of Nations*, is neither an act of sentimentality nor a narrow interpretation of UNICEF concerns.

Progress of all kinds is undermined when millions of children are malnourished and uneducated. Their prospects for future employment and self-reliance are set back by polio, blindness, deafness, mental retardation – disabilities which affect many millions of children and which could now be prevented at very low cost. Specific action to protect children against threats to normal health and development therefore amount to an attack on some of poverty's most fundamental causes as well as some of its most distressing symptoms.

Ninety per cent of the growth of the human body and brain occurs in the first few years of life. The intricate processes of that growth cannot be postponed. That is why action to protect the normal health and growth of children should be at the forefront of development strategies. And that is why children have a legitimate first call on the capacities and concerns of the adult world.

First call for children

Over the last decade, UNICEF has argued that the essence of this principle of first call is that the commitment to protect the growth of children should be a commitment that is maintained in good times and in bad. The meeting of a child's needs for adequate nutrition and full immunization, for education and health care, should not depend on whether a particular political party is in power, or on whether the economy is growing or in recession, or on whether interest rates rise or commodity prices fall, or even on whether a country is at war or peace. The child only has his or her one chance to grow. And for the sake of the child of today, and the world of tomorrow, that one chance should, as far as is humanly possible, be protected against the misfortunes, mistakes, and mismanagements of the adult world.

The commitment to children must therefore be a commitment which is not at the mercy of shifting priorities and political or economic expediencies. It must be a commitment which is maintained in the face of all other demands and difficulties. There will always be something more immediate; there will never be anything more important.

This is the heart of the commitment that has been made specific and measurable by the goals that have been accepted for the year 2000. It is a commitment to renew progress towards the meeting of minimum human needs. And it is a commitment that *The Progress of Nations* will attempt to monitor over the closing years of the twentieth century.

Peter Adamson

LESSONS IN NUMBERS

The overall message of the facts and statistics assembled in these pages is one of significant achievement in the past and realistic hope for the future. As many nations have shown, progress towards meeting minimum human needs can be made in a much shorter timeframe than many would have believed possible. Even in the difficult decade of the 1980s, 20 developing nations have halved their under-five death rates, 50 have more than doubled their immunization levels, and 10 have lifted literacy levels to 90% or more.

The statistics also show that many poor nations are closer to meeting the basic needs of all their citizens than others that are considerably wealthier. Nonetheless, it is the combination of economic growth and effective social policies that is most likely to succeed. And if minimum human needs are to be met in the years ahead, then national and international action will be needed to improve the economic outlook for the developing world, and to ensure that the poor share more equitably in the benefits of growth.

The facts and figures of social development point to one other lesson that is too obvious to mention yet too fundamental to omit: the countries which lag furthest behind are very often the countries disrupted by civil or international war. Peace and stability are the bedrock for the edifice of human progress; war and political turmoil are the tremors that invariably bring that edifice down.

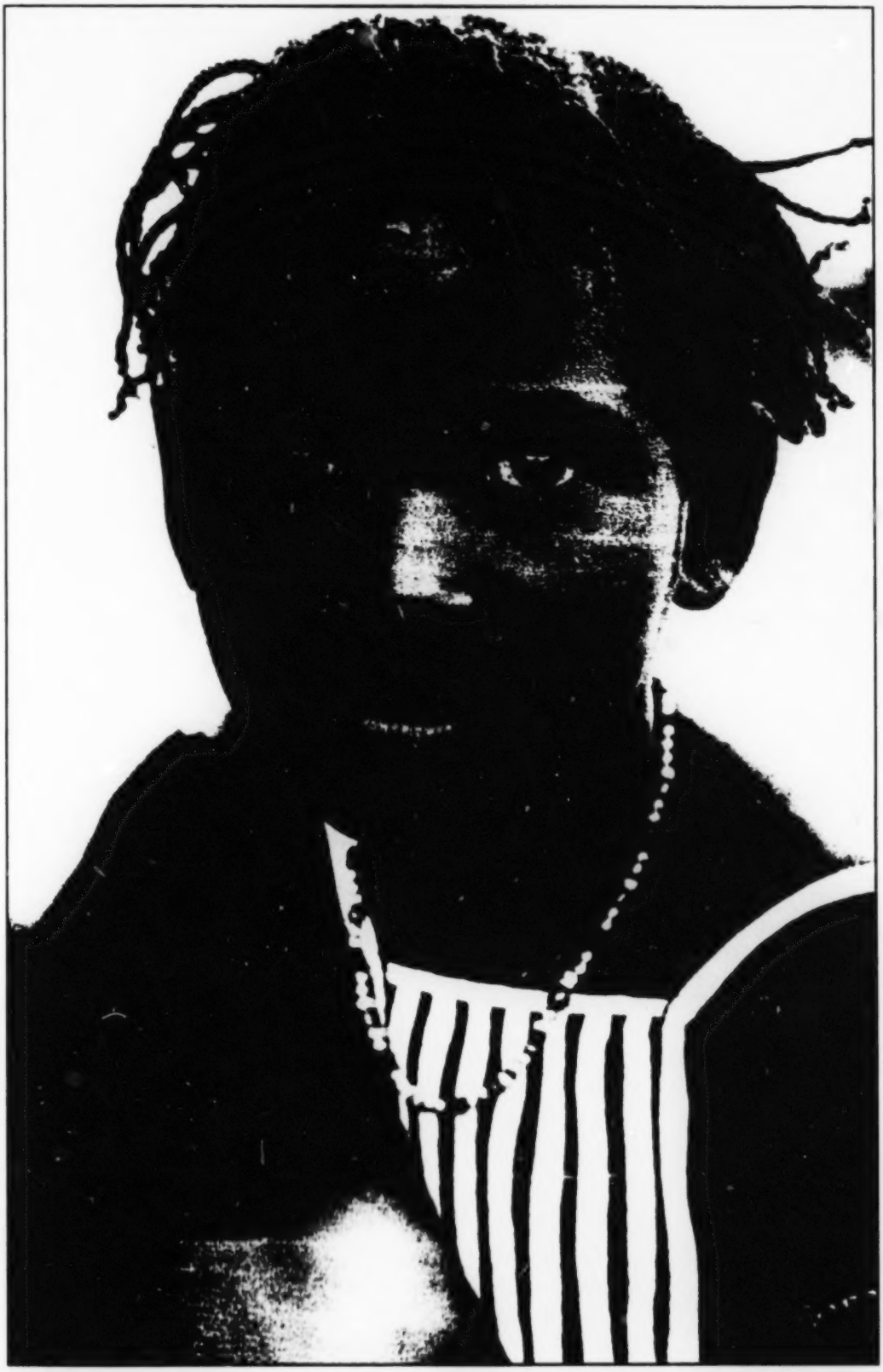
SURVIVAL

A SUMMARY

The number of children who die before the age of five is widely accepted as a key indicator of development.

But under-five mortality is more than just a measure of survival. It is also the best single guide to the quality of life for the far greater numbers of children who survive.

The evidence also suggests that rising confidence in the survival of children is essential to the success of family planning programmes.



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Survival – the measure of all things

For more than a decade, UNICEF has used the reduction of under-five mortality rates (U5MRs) as both an aim and a measure of progress for children. Over that time, the U5MR has come to be known and accepted as one of the most important non-economic indicators of development. Almost all governments have accepted, as a goal for the year 2000, a reduction of U5MR to 70 or less per 1000 births.

The following pages assess the progress of nations when measured by the U5MR. Pages 8 and 9 show the absolute level of achievement; pages 10 and 11 compare actual U5MRs with the level that could reasonably be expected for each country's GNP; pages 12 and 13 show the best performances over time and give examples of the internal disparities which can be hidden by national averages.

The quality of life

Despite its growing acceptance as a key indicator of development, the U5MR is still widely misinterpreted.

The technical definition poses no problems; it is the number of deaths before the age of five for every thousand live births, and it ranges from 5 per 1000 in Sweden to over 300 per 1000 in Niger. But because it is a measure of the quantity of death, it has failed to fully establish itself as an indicator of the *quality of life*. Emphasis on reducing the U5MR therefore lends itself to the criticism that there is little virtue in saving lives if nothing is done to improve the health, nutrition, and life prospects of the survivors.

This amounts to a failure in communication. The U5MR was initially adopted as the prime indicator of progress for children precisely because it reflects many of the elements that are widely regarded as contributing to the quality of life. It is directly affected by, for example, the income and education of parents, the prevalence of malnutrition and disease, the availability of clean water and safe sanitation, the efficacy of health services, and the health and status of women.

The U5MR figures given on the following pages therefore present much more than just a measure of survival; the quality of life for the much greater numbers of children who survive is summed up in the figure for the much smaller numbers of children who die.

This problem of misinterpretation has been compounded, in recent years, by the long-overdue emphasis on the major immediate causes of child death. Three low-cost interventions – vaccination, oral rehydration therapy, and antibiotics – can prevent over half of all child deaths. But expressing their potential in this way has encouraged the view that such interventions are relevant only to the prevention of death and have nothing to offer for the improvement of life. The more widespread and successful such specific interventions become, it might be argued, the less useful the U5MR will be as a measure of child well-being and the more it will become only a measure of survival. Rather than emphasizing the U5MR and the interventions that can reduce it, would it not be better to concentrate on economic development and let child deaths fall in response to generally rising living standards, as happened in the industrialized countries?

Protecting survivors

This argument rests on two misconceptions. First, the conscious attempt to put specific advances in knowledge at the disposal of the majority played a very significant role in reducing child deaths in the industrialized nations. There is always a gap between advances in knowledge and improvements in human well-being; and efforts to close that gap are a mainspring of human progress.

Second, almost all of today's opportunities for reducing the number of children who die also offer significant benefits to the children who survive. Even vaccination, which might seem at first glance to have very little effect save that of preventing death from particular diseases, can have far-reaching effects on the quality of a child's future life.

Nutritional impact

Vaccination against measles, for example, does much more than prevent 1.6 million deaths a year; it also prevents over 50 million non-fatal cases of the disease. And it is increasingly recognized that non-fatal attacks of measles cause subsequent malnutrition, pneumonia, diarrhoea, kwashiorkor, vitamin A loss, encephalitis, conjunctivitis, otitis media, blindness, and deafness. Measles immunization would therefore be an important contribution to children's well-being even if it saved no lives.

Similarly, diarrhoeal disease is a major cause of malnutrition. And oral rehydration therapy – with its message of extra fluids, continued feeding during illness, and catch-up feeding after the illness has passed – has shown that it too can make a contribution to protecting nutritional health.

Frequent illness is a major cause, probably the major cause, of child malnutrition. And the attack on specific diseases or their consequences is an important means of breaking into the self-perpetuating cycle of frequent illness and poor growth, a cycle which inflicts so much damage on the normal mental and physical growth of children, on their receptiveness to education, and on their adult capacities.

Population concern

A second concern over the use of U5MR as an indicator of progress for children is that it tempts some observers into the intuitive but mistaken conclusion that the saving of children's lives will exacerbate the problems of population growth.

In part, this view is encouraged by the indicator itself: a halving of the child death rate, for example from a U5MR of 140 to one of 70 per 1000, can be made to sound like an alarming increase in the number of children; but it could equally well be expressed as a change in the child survival rate from 860 to 930 per 1000 – an increase of less than 8%.

Much more fundamentally, all the evidence suggests that improvements in child survival will lead to a slowing down of population growth rather than an acceleration.

Many strands link falling child deaths to falling birth rates. First, the death of a young child prompts many parents to a new pregnancy. Second, when child death rates are high, parents often insure against an anticipated loss by having more children. Third, empowering parents with the means to protect their children's health and well-being helps to build the confidence which is the *sine qua non* of successful family planning programmes.

That is why contraceptive use does not generally rise above 35% where child death rates remain above 100 per 1000 (see page 35).

Less death, less birth

The league table of child survival on the next page shows that of all the countries with very low incomes the lowest U5MR is to be found in Sri Lanka. A glance at the league table on pages 32 and 33 will show that one of the developing world's lowest fertility rates is also to be found in Sri Lanka. If all developing countries were to achieve the same under-five death rates and the same birth rates as this South Asian island, there would be 10 million fewer child deaths each year – and 37 million fewer births. – *PA*

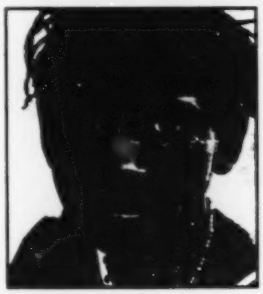
SURVIVAL

LEAGUE TABLE OF

These pages rank the countries of the world according to one of the most revealing of all indicators of the well-being of children – the number of children who die before the age of five (per 1000 live births).

Many aspects of national life are reflected in this one statistic – including the income and education of parents, the prevalence of malnutrition and disease, the availability of clean water, the efficacy of health services, and the health and status of a nation's women.

The under-five death rate is therefore a measure not just of the quantity of death but of the quality of life.



SUB-SAHARAN AFRICA

1	Mauritius	25
2	Botswana	60
3	South Africa	72
4	Kenya	75
5	Namibia	81
6	Zimbabwe	88
7	Cameroon	121
8	Côte d'Ivoire	127
9	Togo	140
10	Benin	149
11	Senegal	150
12	Burkina Faso	154
13	Lesotho	157
14	Ghana	170
15	Madagascar	173
16	Tanzania	178
17	Burundi	179
▶	*Regional average*	*183*
18	Uganda	185
19	Zaire	189
20	Nigeria	191
21	Zambia	200
22	Mauritania	209
23	Ethiopia	212
24	Liberia	218
25	Rwanda	222
26	Mali	225
27	Malawi	228
28	Mozambique	292
29	Niger	320
	Angola	NO DATA
	C. African Rep.	NO DATA
	Chad	NO DATA
	Congo	NO DATA
	Gabon	NO DATA
	Guinea	NO DATA
	Guinea-Bissau	NO DATA
	Sierra Leone	NO DATA
	Somalia	NO DATA

MIDDLE EAST and NORTH AFRICA

1	Kuwait	17
2	United Arab Emirates	23
3	Jordan	32
4	Oman	33
5	Syria	42
5	Tunisia	42
7	Saudi Arabia	43
8	Algeria	61
9	Iran	62
10	Morocco	66
11	Egypt	72
▶	*Regional average*	*86*
12	Turkey	91
13	Iraq	143
14	Sudan	169
	Lebanon	NO DATA
	Libya	NO DATA
	Yemen	NO DATA

SOUTH ASIA

1	Sri Lanka	21
2	India	126
▶	*Regional average*	*131*
3	Nepal	132
4	Bangladesh	133
5	Pakistan	138
6	Bhutan	205
	Afghanistan	NO DATA

WORLD AVERAGE

Child deaths per 1000 births

Statistics: weak but the best available

Many of the statistics used for under-five deaths are estimates for 1991 based on mathematical models rather than on recent measurements at national level. They are therefore inadequate; but they are the best available.

For about half of the countries of sub-Saharan Africa, on-the-ground national statistics either do not exist at all or date from the 1970s. For nearly half the countries of Asia, there are no statistics on child deaths more recent than 1986. In the Americas, the figures for Brazil and Mexico reflect information which is nearly ten years old.

The statistics are presented, with full acknowledgement of their weaknesses, in order to provide the best available guide to national achievement, and to help stimulate improved monitoring. The present statistical weakness is in part a function of underdevelopment; but it also reflects the low priority given to the promotion and measurement of basic improvements in the lives of the majority.

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CHILD DEATHS

EAST ASIA and PACIFIC

1	Hong Kong	7
2	Singapore	8
3	Korea, Rep.	10
4	Malaysia	20
5	Korea, Dem.	34
6	Thailand	35
7	China	43
8	Viet Nam	52
▶	*Regional average*	*57*
9	Philippines	61
10	Papua New Guinea	79
11	Mongolia	82
12	Indonesia	111
13	Myanmar	117
14	Lao Rep.	148
	Cambodia	NO DATA

CENTRAL AMERICA and CARIBBEAN

1	Cuba	12
2	Costa Rica	15
2	Jamaica	15
4	Panama	20
5	Trinidad and Tobago	23
6	Mexico	36
▶	*Regional average*	*43*
7	Dominican Rep.	53
8	Honduras	60
9	El Salvador	67
10	Guatemala	80
11	Nicaragua	81
12	Haiti	137

SOUTH AMERICA

1	Chile	20
1	Colombia	20
3	Uruguay	22
4	Argentina	25
4	Venezuela	25
6	Paraguay	35
▶	*Regional average*	*54*
7	Ecuador	61
8	Brazil	67
9	Peru	69
10	Bolivia	122

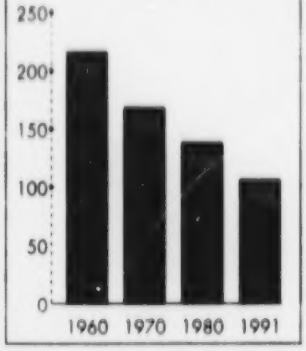
INDUSTRIALIZED COUNTRIES

1	Sweden	5
2	Japan	6
3	Finland	7
4	Netherlands	8
4	Switzerland	8
4	Canada	8
4	Norway	8
8	United Kingdom	9
8	France	9
8	Austria	9
8	Denmark	9
8	Germany	9
8	Spain	9
14	Italy	10
14	Australia	10
14	Ireland	10
14	Belgium	10
14	New Zealand	10
19	USA	11
19	Greece	11
▶	*Group average*	*11*
21	Israel	12
21	Portugal	12
23	Czechoslovakia (former)	13
24	Poland	17
24	Hungary	17
26	Bulgaria	21
27	Romania	34

Child death rates halved since 1960

Deaths down

Under-five deaths per 1000 births in the developing world



Under-five mortality rates have been cut by half in the last 30 years. Despite population growth, the absolute number of child deaths is also declining. There are today an estimated 13 million child deaths a year or about 35,000 per day – down from 15 million, or more than 40,000 a day, in the early 1980s.

About two thirds of those deaths occur in just ten countries. Population size is not the only factor. China and India have about the same number of births – but India has three times as many child deaths. Nor is economic level necessarily decisive (see following pages).

Two thirds in 10 countries

Annual under-five deaths

India	3,224,000
China	1,071,000*
Nigeria	1,012,000
Pakistan	695,000
Bangladesh	583,000
Indonesia	572,000
Ethiopia	542,000
Zaire	353,000
Brazil	247,000
Tanzania	231,000
Total	**8,530,000**

* Recent estimates put China's under-five mortality rate at 43 rather than the 27 previously estimated. This translates into an absolute increase of over 400,000 child deaths, taking the annual total to over 1 million.

TARGET

A one-third reduction in 1990 under-five mortality rates (or to 70 per 1000 – whichever is lower).

FOR THE YEAR 2000

SURVIVAL

NATIONAL PERFOR

The well-being of a nation's children, as reflected by under-five mortality rates, is not determined only by economic development.

Some countries are achieving much more than could be expected for their levels of national income: others are achieving much less.

These pages therefore present a different way of looking at the progress of nations. The figure given opposite each country name is that country's national performance gap – the gap between the actual level of under-five mortality and the level that could be expected for the country's GNP per capita (see box this page).

SUB-SAHARAN AFRICA

1	Kenya (75)	+69
2	Tanzania (178)	+50
3	Zimbabwe (88)	+15
4	Mauritius (25)	+11
4	Uganda (185)	+11
6	Madagascar (173)	+4
7	Ethiopia (212)	+3
8	Burundi (179)	-2
9	Togo (140)	-9
10	Burkina Faso (154)	-12
11	Benin (149)	-13
12	Zaire (189)	-15
13	Namibia (81)	-19
14	Botswana (60)	-26
15	Côte d'Ivoire (127)	-32
16	Nigeria (191)	-36
17	Ghana (170)	-37
18	South Africa (72)	-38
19	Mozambique (292)	-39
20	Cameroon (121)	-47
21	Lesotho (157)	-50
22	Malawi (228)	-57
23	Senegal (150)	-58
24	Rwanda (222)	-60
25	Mali (225)	-67
26	Zambia (200)	-71
27	Liberia (218)	-93
27	Mauritania (209)	-93
29	Niger (320)	-167
	Angola	
	Central African Rep.	
	Chad	
	Congo	
	Gabon	
	Guinea	
	Guinea-Bissau	
	Sierra Leone	
	Somalia	

MIDDLE EAST and NORTH AFRICA

1	Egypt (72)	+31
2	Jordan (32)	+30
3	Syria (42)	+21
4	Tunisia (42)	+7
5	Morocco (66)	+2
6	Kuwait (17)	-6
7	Oman (33)	-12
8	U. Arab Emirates (23)	-14
9	Algeria (61)	-21
10	Saudi Arabia (43)	-25
11	Iran (62)	-26
12	Sudan (169)	-40
13	Turkey (91)	-48
14	Iraq (143)	-94
	Lebanon	
	Libya	
	Yemen	

SOUTH ASIA

1	Sri Lanka (21)	+97
2	Nepal (132)	+56
3	Bangladesh (133)	+41
4	India (126)	+20
5	Pakistan (138)	-5
6	Bhutan (205)	-17
	Afghanistan	

NATIONAL PERFORMANCE GAP

See also pages 50 and 51

Social miles per economic gallon

Using data on GNP and under-five mortality from all nations, it is possible to calculate what level of under-five mortality a country could reasonably be expected to have achieved for any given level of GNP per capita. The difference between the actual and expected level is the national performance gap.

An average-performing country with a per capita GNP of $400, for example, could be expected to have an under-five mortality rate of approximately 140; if the actual under-five mortality rate is 120, then that country's national performance gap is +20, meaning that its under-five mortality rate is 20 points better than expected for its GNP per capita.

The tables on these pages show the national performance gap in under-five mortality for all countries. The figure in parentheses is the actual level of under-five mortality.

National performance gaps relevant to the indicators of health, nutrition and education are given on pages 50 and 51.

ANCE GAPS

EAST ASIA and PACIFIC

1	Viet Nam (52)	+116
2	China (43)	+95
3	Myanmar (117)	+57
4	Korea, Dem. (34)	+38
5	Philippines (61)	+29
6	Lao Rep. (148)	+23
7	Malaysia (20)	+15
8	Thailand (35)	+12
9	Korea, Rep. (10)	+9
10	Hong Kong (7)	+5
10	Mongolia (82)	+5
12	Papua N. Guinea (79)	+4
12	Singapore (8)	+4
14	Indonesia (111)	-7
	Cambodia	

CENTRAL AMERICA and CARIBBEAN

1	Nicaragua (81)	+63
2	Honduras (60)	+48
3	Cuba (12)	+47
4	Jamaica (15)	+37
5	Costa Rica (15)	+26
6	Dominican Rep. (53)	+20
7	Panama (20)	+18
8	Trinidad/Tobago (23)	+5
9	Haiti (137)	+1
10	El Salvador (67)	-2
11	Mexico (36)	-4
12	Guatemala (80)	-6

SOUTH AMERICA

1	Colombia (20)	+35
2	Paraguay (35)	+22
3	Chile (20)	+18
4	Uruguay (22)	+10
5	Venezuela (25)	+9
6	Argentina (25)	+8
7	Ecuador (61)	+7
8	Peru (69)	-1
9	Bolivia (122)	-23
10	Brazil (67)	-36

INDUSTRIALIZED COUNTRIES

1	Poland (17)	+26
2	Bulgaria (21)	+22
2	Czechoslovakia* (13)	+22
4	Romania (34)	+19
5	Hungary (17)	+16
6	Greece (11)	+9
6	Portugal (12)	+9
8	Ireland (10)	+4
8	Spain (9)	+4
10	New Zealand (10)	+3
10	Sweden (5)	+3
12	Netherlands (8)	+2
13	Canada (8)	+1
13	Finland (7)	+1
13	Israel (12)	+1
13	Japan (6)	+1
13	United Kingdom (9)	+1
18	Australia (10)	0
18	Austria (9)	0
18	France (9)	0
18	Italy (10)	0
18	Norway (8)	0
23	Belgium (10)	-1
23	Denmark (9)	-1
23	Germany (9)	-1
26	Switzerland (8)	-2
27	USA (11)	-3
	Albania	

Not by GNP alone

The internationally accepted goal is that all countries should be able to reduce child death rates to 70 per 1000 or less by the year 2000. The table shows seven poor countries that have already achieved that target.

Demographic trends suggest that the phase of under-five mortality decline from about 150 to about 70 is associated with steep falls in birth rates. The majority of developing countries are now entering this phase, during which progress in reducing under-five mortality should pay major dividends in falling fertility.

Per capita GNP below $1000, under-five mortality below 70

	GNP per capita $	Under-five mortality rate
Viet Nam	240	52
China	370	43
Sri Lanka	500	21
Honduras	570	60
Philippines	740	61
Dominican Rep.	950	53
Korea, Dem.	970	34

Egypt, with a per capita GNP of $620, has an estimated under-five mortality rate of 72 and is very close to reaching the year 2000 goal.

Sources: See footnote, UNICEF, GNP, World Bank, World Bank Atlas 1992.

Achievement can also be assessed by looking at the rate of progress over time. The tables on pages 52 and 53 show, for all countries, the rate of progress achieved in the 1980s and the rate necessary in the 1990s if the year 2000 goal is to be met.

Countries with 1990 under-five mortality rates of 200 or more will need to make very rapid progress to reach the target. But some countries have shown that reducing child deaths by half, or even two thirds, over a ten-year period is not impossible (see page 12).

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Child death rates in industrialized nations were as high in 1900 as they are in Africa in 1990. Even in the 1960s, under-five mortality in Europe was higher than in most of South America today.

With more knowledge and technology, developing countries can now reduce child deaths far more quickly. Twenty nations have halved their under-five mortality rates in the last ten years.

But even rapid reductions can hide great disparities. Child death rates in deprived areas are typically two or three times higher than in capital cities.

Some good news for children of North Africa and the Middle East

20 nations halve child death rates in 10 years

Arab states dominate the list of nations that have made most progress in reducing child deaths over the past decade (see table). Five of the ten countries with the largest percentage reduction in under-five mortality are to be found in North Africa and the Middle East.

The list is headed by Colombia with a 66% reduction in its under-five death rate between 1980 and 1991. Colombia was one of the first countries to mobilize behind mass immunization in the mid-1980s, and for almost a decade, new knowledge about child care has been promoted by Colombian schools, the mass media, the Catholic clergy, and non-governmental organizations, as well as by the health services.

The second and third-ranked countries, Oman and the United Arab Emirates, have the advantage of oil wealth and high per capita GNPs; but both have managed to convert that advantage into a two-thirds reduction in child death rates in only 11 years.

Sri Lanka makes the top ten despite having already achieved a low under-five mortality rate at the beginning of the period. High levels of female literacy, low birth rates, and health services for the majority, go a long way towards explaining Sri Lanka's success. Low birth rates are part cause and part consequence of low under-five death rates (see page 7).

Halving child deaths

Under-five mortality rates

	1980	1991	% fall
Colombia	59	20	66
Oman	95	33	65
U. Arab Emirates	64	23	64
Jamaica	39	15	62
Portugal	31	12	61
Egypt	180	72	60
Sri Lanka	52	21	60
Tunisia	102	42	59
Algeria	145	61	58
Mexico	81	36	56
Cuba	26	12	54
Morocco	145	66	54
Greece	23	11	52
Jordan	66	32	52
Malaysia	42	20	52
Saudi Arabia	90	43	52
Iran	126	62	51
Kuwait	35	17	51
Viet Nam	105	52	50
Uruguay	42	22	48

SOURCE UNICEF

Rising deaths in 7 countries

While overall child death rates in the developing world declined by over 20% in the 1980s, best available estimates suggest that seven countries went against this trend by recording a rise in under-five mortality:

Under-five mortality

	1980	1991	% rise
Iraq	83	143	72
Zambia	160	200	25
Mozambique	269	292	9
Ghana	157	170	8
Uganda	181	185	2
Angola	261	—	—
Afghanistan	280	—	—

No 1991 estimates are available for Angola and Afghanistan but the UNICEF view is that child deaths have risen, as they have in Iraq and Mozambique, because of war or internal conflict.

In Zambia, falling copper prices and austerity programmes designed to cope with the nation's heavy debts have lowered incomes, pushed up food prices, and cut health and nutrition programmes. Per capita income fell sharply over the decade in Ghana and Uganda, and adjustment programmes to cope with debt have often meant abolishing food subsidies and cutting back essential services. Other set-backs have included recurring droughts and famine, the resurgence of malaria, and the growing toll of AIDS.

SOURCES UNICEF

New estimates for former USSR

Estimates for under-five death rates in the 15 countries of the former Soviet Union have just become available. They span a broad range from 20 in Lithuania (about the same as Chile or Malaysia) to 92 in Turkmenistan (slightly higher than in Zimbabwe and much higher than in Egypt). Six of the republics have child death rates higher than the average for Central America and the Caribbean.

Under-five mortality 1991

Lithuania	20
Belarus	23
Estonia	25
Ukraine	25
Latvia	27
Georgia	30
Russian Federation	33
Armenia	36
Moldova	37
Kazakhstan	51
Azerbaijan	55
Kyrgyzstan	61
Uzbekistan	70
Tajikistan	87
Turkmenistan	92
USSR (former)	**43**

SOURCE US Bureau of the Census, unpublished data

DISPARITY

The big leap forward – but not so long ago

Spain and Italy did not reach target until 1960s

Seventy years ago, child death rates in the cities of the industrialized world were higher than the average for Africa today. Respiratory infections and diarrhoeal disease were leading killers. From the 1920s progress was rapid – thanks not only to rising living standards but also to conscious efforts to reach all parents with new knowledge about hygiene and better ways to promote the growth and health of children.

In 1990, the World Summit for Children set the target of reducing child death rates to 70 per 1000 or less in all countries by the year 2000. The following chart shows when today's industrialized countries – and the first developing countries – reached that target.

1930		
Iceland	New Zealand	Norway
1935		
Australia Switzerland	Netherlands	Sweden
1940		
United Kingdom	United States	
1945		
Denmark	Finland	
1950		
Canada	Ireland	Israel
1955		
Austria Czechoslovakia Luxembourg	Belgium France West Germany	Cyprus Japan
1960		
Bulgaria Italy Spain	East Germany Malta	Hong Kong Singapore
1965		
Barbados Jamaica Uruguay	Greece Poland	Hungary Trinidad and Tobago
1970		
Cuba Malaysia	Fiji Panama	Kuwait Romania

Disparities hidden

Most of the child survival statistics presented in these pages are national averages. But inequalities within countries can be as great as inequalities between countries; a single figure for a whole nation can mask disparities between male and female, urban and rural, black and white, majority and minority, or rich and poor.

The following table shows the under-five mortality rates of seven countries, followed by examples of the widely differing mortality rates that lie behind this national average.

If few countries produce regular national statistics for under-five mortality, even fewer produce statistics broken down by gender, location, state, occupation, or caste. Therefore the following estimates have had to be taken from many different years. This explains why the national averages given are different from the 1991 estimates given in the league tables and elsewhere in *The Progress of Nations*. The year indicated is usually the mid-point of a multi-year survey period.

Under-five mortality

Nigeria (1985)	**191**	**Egypt (1983)**	**132**
South-east	144	Cities	89
North-west	244	Rural areas	164
India (1988)*	**94**	**Mexico (1982)**	**71**
Uttar Pradesh	123	Cities	32
Kerala	28	Rural areas	104
Kenya (1984)	**91**	**Indonesia (1982)**	**111**
Central region	47	Yogyakarta Province	56
Coast region	156	West Java	141
Sri Lanka (1982)	**42**		
Tea estates	73		

*Data for rural areas is slightly higher.

And in the United States ...

Similar disparities are to be found in industrialized countries. In the United States, for example, San Francisco has an infant mortality rate of 7 – the same as Norway or Switzerland. Detroit, on the other hand, ranks below Cuba, and Washington DC finds itself at the same level as Jamaica or Kuwait.

If infant mortality in the United States is broken down by race, then white infant mortality is seen to be 8 per 1000 – putting it among the best in the world alongside Norway, Switzerland, Canada and Japan.

Black infant mortality, by contrast, is 18 per 1000 – higher than in Bulgaria, Poland, or Cuba. Babies born to black American mothers also run double the risk of low birth weight.

The infant mortality rate is the number of deaths *by age one* per 1000 live births.

USA – black infant mortality is double

SOURCES: USA data from National Center for Health Statistics and National Commission to Prevent Infant Mortality, "Losing Ground". *The health of America's next generation*, 1990. Other data from UNICEF and Institute for Resource Development, Demographic and Health Surveys.

NUTRITION

A SUMMARY

The starving child has become the most common symbol of malnutrition. Yet it misrepresents the problem.

Most malnutrition is invisible. most malnourished children are not hungry. and the most common cause of malnutrition is not lack of food in the home.

The problem of micronutrient malnutrition is even less widely appreciated. Yet the lack of vitamin A is blinding 250,000 children every year. and an estimated 120,000 children are being born brain-damaged every year because their mothers lack iodine in their diet.

Myths of malnutrition stand in way

The league table of malnutrition on the following pages is based on the best available estimates of the numbers of children under five who are more than two standard deviations below the median weight for age. The goal for the year 2000 is a halving of 1990 malnutrition rates in every country.

This goal is well within reach over the remaining years of the 1990s. The main barrier to its achievement is not the absolute lack of food or resources but the misunderstanding of the problem and the lack of sustained political commitment to its solution.

The starving child has become the most common symbol of malnutrition. Yet it misrepresents the problem. Visible malnutrition, usually the result of exceptional circumstances, affects only about 1% or 2% of the world's children. The deeper problem is the ordinary, unexceptional malnutrition which cannot usually be detected without knowing the age and exact weight or height of the child but which nonetheless stunts the mental and physical growth of one third of the developing world's children.

Frequent illness

Some families are unable to feed their children adequately because of drought, famine, war, or poverty. Only political and economic action, often involving land reform and investment in food production by and for the poor, can solve this problem. But the great majority of malnourished children live in homes where older children and adults have enough to eat and where it is clearly possible to provide enough food to meet the relatively small requirements of a young child.

In such circumstances, the most important causes of malnutrition include:

Frequent illness All illnesses, and especially diarrhoea and measles, have a nutritional impact. They reduce appetite. They inhibit the absorption of food. They burn away calories in fever. They drain away nutrients in vomiting and diarrhoea. Frequent illness is therefore the most common cause of malnutrition and poor growth.

Bottle-feeding In poor communities, babies who are bottle-fed are many times more likely to be malnourished. Breastmilk meets all the nutritional needs of the very young child; it also 'immunizes' infants against common diseases. Infant formulas, on the other hand, may be overdiluted with unsafe water and fed to the child from unsterile bottles and teats.

Faltering growth

Low birth weight Low birth weight, caused by the poor nutritional health of the mother (including anaemia) and by too frequent childbirth, predisposes children to malnutrition throughout the early years.

Weaning practices If weaning begins too early, then the risk of disease and malnutrition increases. If it begins too late, growth begins to falter.

Infrequent feeding Young children have smaller stomachs and proportionately higher energy needs than adults. They therefore need smaller meals but more frequent feeding – five or six times a day – with small amounts of energy-rich oil or fats added to the family's normal food.

Vitamin A

Less publicized still is the problem of micronutrient malnutrition.

The lack of vitamin A, in particular, permanently blinds 250,000 children every year in the developing world, and leaves tens of millions more susceptible to the three leading causes of child death – diarrhoeal disease, measles, and pneumonia. About a third of the world's children live in areas where the intake of vitamin A is inadequate. Recent studies have shown that a child's chances of dying from common infections rise by 20% if he or she has even a mild level of vitamin A deficiency. The solution is either the addition of small amounts of fruit or green vegetables to the child's daily diet, or supplementation with vitamin A capsules costing 5 cents each and given three times a year.

Cretinism

Similarly, it is possible to bring an end to the iodine deficiency disorders (IDD) in those areas of the world where soils and diets lack iodine. Over 200 million are affected by the most visible symptom of IDD – the swelling of the thyroid gland which produces goitres in the neck. But the severest symptom is the overt cretinism of approximately 6 million people. The unborn child is particularly susceptible; an estimated 120,000 children are being born brain-damaged every year because their mothers lack iodine. Millions more are growing up stunted, listless, mentally retarded, and incapable of normal speech or hearing. An estimated 50 million children are not able to take full advantage of primary education because of IDD.

The problem can be inexpensively solved, as it has been in most industrialized countries, by adding iodine to a universally consumed product – common salt. Iodization of salt costs about 5 cents per person per year. While the legislation, technologies, and control procedures are being put in place, populations at risk can be given iodine capsules twice a year at a cost of about 15 cents per person.

A list of countries with IDD problems, including an indication of whether they are being acted on or ignored, is published on page 19.

Large scale, low cost

All of these manifestations of malnutrition undermine the development of children and reduce their eventual capacity to contribute to and benefit from the progress of their families and their nations.

Yet it has been demonstrated in the 1980s that both protein-energy malnutrition and micronutrient deficiencies can be overcome on a large scale and at low cost if the right strategies are adopted and if communities are involved in making low cost solutions work. In the words of the World Bank, "a direct attack on malnutrition is needed ... and governments willing to make that effort now have effective and affordable measures to make it happen."

Year 2000 goals

Drawing on advances in understanding of the nutritional problem and its potential solutions, the 1990 World Summit for Children adopted the following specific goals for the year 2000:

- A halving of severe and moderate protein-energy malnutrition in children under five
- A reduction in the rate of low birth weight to less than 10% in all countries
- A reduction of at least one third in 1990 levels of iron-deficiency anaemia in women
- The virtual elimination of iodine and vitamin A deficiencies.

An essential early step towards these goals must be the closer monitoring of nutritional problems. At the moment, few nations have regular statistics on what percentages of children are below acceptable levels of weight for age or are suffering from micronutrient disorders. There could be no more important guide to policy – or more important measure of progress. – *PA*

NUTRITION

LEAGUE TABLE OF

These pages rank all countries of the developing world according to the percentage of their children estimated to be malnourished in the latest year for which information is available.

Malnutrition, caused as much by frequency of illness and lack of information as by the absolute lack of food, stunts the mental and physical growth of children and saps the economic and social development of nations.

Yet few countries monitor malnutrition in children on any regular basis (see box facing page).

SUB-SAHARAN AFRICA

		%
1	Zimbabwe	12
1	Côte d'Ivoire	12
3	Kenya	14
4	Botswana	15
5	Lesotho	16
6	Cameroon	17
7	Liberia	20
8	Senegal	22
9	Guinea-Bissau	23
9	Sierra Leone	23
9	Uganda	23
12	Congo	24
12	Malawi	24
12	Mauritius	24
12	Togo	24
16	Zambia	25
17	Ghana	27
18	Namibia	29
19	Mali	31
▶	*Regional average*	*31*
20	Madagascar	33
20	Rwanda	33
22	Nigeria	36
23	Ethiopia	38
23	Burundi	38
25	Mauritania	48
25	Tanzania	48
27	Niger	49
	Angola	NO DATA
	Benin	NO DATA
	Burkina Faso	NO DATA
	C. African Rep.	NO DATA
	Chad	NO DATA
	Gabon	NO DATA
	Guinea	NO DATA
	Mozambique	NO DATA
	Somalia	NO DATA
	South Africa	NO DATA
	Zaire	NO DATA

MIDDLE EAST and NORTH AFRICA

		%
1	Jordan	6
1	Kuwait	6
3	Algeria	10
3	Egypt	10
3	Tunisia	10
6	Iraq	12
7	Morocco	16
8	Sudan	20
▶	*Regional average*	*24*
9	Iran	43
10	Yemen	53
	Lebanon	NO DATA
	Libya	NO DATA
	Oman	NO DATA
	Saudi Arabia	NO DATA
	Syria	NO DATA
	Turkey	NO DATA
	U. Arab Emirates	NO DATA

SOUTH ASIA

		%
1	Sri Lanka	29
2	Bhutan	38
3	Pakistan	40
▶	*Regional average*	*60*
4	India	63
5	Bangladesh	66
	Afghanistan	NO DATA
	Nepal	NO DATA

DEVELOPING WORLD AVERAGE

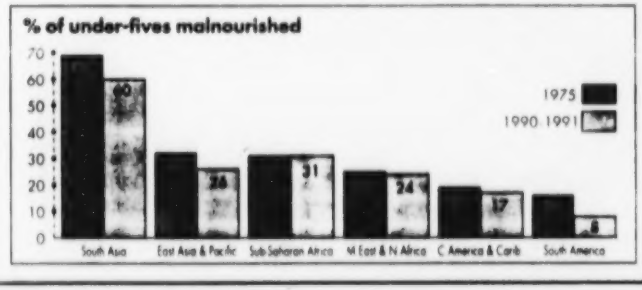
% of under-fives malnourished

The decline of malnutrition

Malnutrition rates have declined in most regions but one child in three is not growing properly.

The biggest nutrition problem is to be found not in Africa but in South Asia – where the proportion of malnourished children is twice as high. But sub-Saharan Africa is the only region where malnutrition has not declined over the last 15 years.

SOURCE: Adapted from United Nations Administrative Committee on Coordination Subcommittee on Nutrition. Second report on the world nutrition situation. 1992



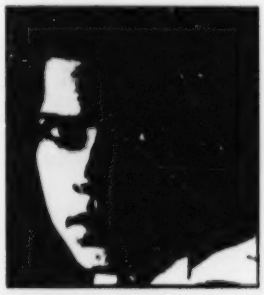
MALNUTRITION

EAST ASIA and PACIFIC

		%
1	Singapore	14
2	China	21
3	Thailand	26
▶	*Regional average*	*26*
4	Myanmar	32
5	Philippines	34
6	Papua New Guinea	35
7	Lao Rep.	37
8	Indonesia	40
9	Viet Nam	42
	Cambodia	NO DATA
	Hong Kong*	NO DATA
	Korea, Dem.	NO DATA
	Korea, Rep.	NO DATA
	Malaysia	NO DATA
	Mongolia	NO DATA

CENTRAL AMERICA and CARIBBEAN

		%
1	Costa Rica	6
2	Trinidad and Tobago	7
2	Jamaica	7
4	Nicaragua	11
5	Dominican Rep.	13
6	Mexico	14
7	El Salvador	15
8	Panama	16
▶	*Regional average*	*17*
9	Honduras	21
10	Guatemala	34
11	Haiti	37
	Cuba	NO DATA



SOUTH AMERICA

		%
1	Chile	3
2	Paraguay	4
3	Venezuela	6
4	Brazil	7
4	Uruguay	7
▶	*Regional average*	*8*
6	Colombia	10
7	Bolivia	13
7	Peru	13
9	Ecuador	17
	Argentina	NO DATA

INDUSTRIALIZED COUNTRIES

Most industrialized nations do not publish statistics showing the percentage of their children whose weight for age is below two standard deviations from the median. This does not mean that malnutrition does not exist in the richer nations. In the United States, for example, it is estimated that one child in eight goes hungry.

In the former Soviet republics, malnutrition threatens on a significant scale as wages fall behind rising food prices. In Albania, a third of all children are reported malnourished.

In most industrialized countries, undernutrition persists among the poorest groups. But the commonest form of child malnutrition is obesity. North American children obtain as much as 50% of their energy intake from fats, double the recommended proportion. According to the World Health Organization, 40% of older Europeans are obese.

Similar patterns are now emerging in some developing countries.

Half have no data since 1984

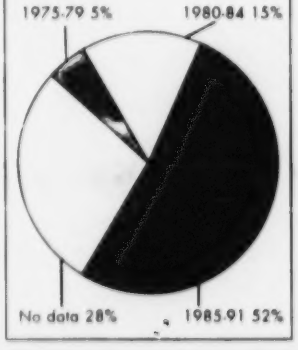
These tables are largely based on out-of-date information about malnutrition. The pie chart shows just how bad the statistical situation is. For almost half of the developing countries, there is either no information at all or no information from the last decade. Yet this is the best information the world has on child malnutrition – a key indicator of children's mental and physical development.

The estimates on these pages are taken from the latest national surveys – which in many cases means surveys from the mid-1980s. In a few cases, information from more local surveys has been used if it was judged to be approximately representative of the national situation.

The definition used in these tables includes both moderate and severe malnutrition (% of children below the level of two standard deviations from the median weight for age).

More detailed information on national estimates of child malnutrition can be obtained from *Child malnutrition: progress toward the World Summit for Children goal* (UNICEF, 1993). Regional and global trends in malnutrition are described in the *Second report on the world nutrition situation* (United Nations Administrative Committee on Coordination/Subcommittee on Nutrition (ACC/SCN), 1992). Further information on the measurement of malnutrition can be found in *Appropriate uses of anthropometric indices in children* (ACC/SCN, 1990).

Latest year when malnutrition was measured (survey of data from 99 developing countries)



TARGET

A 50% reduction in the 1990 level of severe and moderate malnutrition among the world's under-fives.

FOR THE YEAR 2000

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ACHIEVEMENT AND

Malnutrition takes many forms and has many causes.

Lack of food may or may not be a factor.

Progress depends on reducing the frequency and nutritional impact of common illnesses, on reversing the trend towards bottle-feeding, on improving the way in which children are weaned, on informing parents about the special feeding needs of the young child, on preventing low birth weight, and on national action to control the 'hidden hunger' of micronutrient deficiencies.

Despite the image – some African countries have malnutrition rates below 15%

Some poor countries do better in nutrition

About one child in three in the developing world is malnourished and will not grow to the potential with which he or she was born.

Although poor growth is closely tied to poverty, many poor countries have succeeded in reducing malnutrition to lower levels than in countries with higher levels of average income (see chart).

Such weight-for-age comparisons between countries are often challenged on the basis that 'some races are smaller than others'. But young children in good nutritional health grow to the same patterns whether they live in apartments on Fifth Avenue or slums in Bombay.

Similarly, the widespread idea that malnutrition is more common among girls does not seem to be borne out by the facts. A 1993 review* of the evidence concludes that "male and female rates of malnutrition are very similar for most countries and where differences are sizable it is not consistently females who are worse off".

*Lisa Mosley, 'Who's Hungry And How Do We Know?', United Nations University Food Symposium

For richer, for poorer

GNP per capita below $1000, malnutrition below 15%

	% under-fives underweight	GNP per capita 1991 $
Egypt	10	620
Zimbabwe	12	620
Côte d'Ivoire	12	690
Dominican Rep.	13	950
Bolivia	13	650
Kenya	14	340

GNP per capita more than $1000, malnutrition 15% or more

Namibia	29	1120
Thailand	26	1580
Mauritius	24	2420
Congo	24	1120
Ecuador	17	1020
Morocco	16	1030
El Salvador	15	1070
Botswana	15	2590

Underweight: Progress Toward the World Summit for Children Goals, pp. 122-123, UNICEF, World Bank, World Bank, 1993

Developing countries end free infant formula

Of more than 70 developing countries where free or subsidized infant formulas were commonly distributed in maternity wards, nearly all have now banned the practice.

WHO and UNICEF have long argued that what happens in hospitals and maternity units is one of the biggest influences on whether mothers decide to breastfeed or bottle-feed. Banning the free or low-cost distribution of commercial infant formulas is a key element in the 'ten steps to successful breastfeeding' that many thousands of hospitals have adopted at the request of WHO and UNICEF in the last two years.

The countries that have taken action are:

Algeria
Argentina
Bahrain
Bangladesh
Barbados
Belize
Benin
Bhutan
Bolivia
Botswana
Brazil
Cameroon
Chile
China
Colombia
Congo
Costa Rica
Côte d'Ivoire
Cuba
Dominican Rep.
Ecuador
Egypt
El Salvador
Ethiopia
Fiji
Gabon
Ghana
Guatemala
Honduras
India
Indonesia
Iran
Jamaica
Jordan
Kenya
Lebanon
Madagascar
Malaysia
Maldives
Mexico
Morocco
Mozambique
Namibia
Nepal
Niger
Nigeria
Oman
Pakistan
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Saudi Arabia
Sri Lanka
Sudan
Swaziland
Syria
Tanzania
Thailand
Trinidad and Tobago
Tunisia
Turkey
United Arab Emirates
Uruguay
Venezuela
Viet Nam
Yemen
Zaire
Zimbabwe

DISPARITY

China and India – half of all the malnourished children in the world

80% in 10 countries

Eighty per cent of the world's malnourished children are to be found in just ten countries.

Of the estimated total of 190 million underweight children, 120 million or about 60% live in four of the most populous Asian countries – China, India, Pakistan, and Bangladesh. India alone has more than 70 million malnourished children – two and a half times as many as the whole of sub-Saharan Africa.

The concentration of malnutrition in Asia is not just a question of population size. The proportion of children who are malnourished is also much higher. More than 60% of all the young children in India and Bangladesh are underweight – twice as high as the average for sub-Saharan Africa.

Two other nutritional problems – anaemia and low birth weights – are also much more common in South Asia than anywhere else in the world.

The ten nations with 80% of the world's malnourished children are:

	Number of malnourished under-fives (millions)
India	72
China	24
Bangladesh	13
Pakistan	9
Indonesia	9
Nigeria	8
Viet Nam	4
Iran	4
Ethiopia	4
Philippines	3
Total	150

[illegible] Development Programme, Economic and Social Survey of Asia and the Pacific 1991

Breastfeeding – top 10 countries

The deaths of more than 1 million infants a year could be prevented if all babies were exclusively breastfed for the first few months of life, according to estimates by the World Health Organization.

Figures on exclusive breastfeeding are only available for 32 developing countries. Because so few countries keep statistics, the range shown is wide – enabling Peru to make the top ten with only about one third of its infants being exclusively breastfed. For countries such as Thailand, Brazil, Ghana and Nigeria, the percentage falls to below 5%.

	% infants exclusively breastfed (0-3 months)
Burundi	89
Uganda	70
Bolivia	59
Morocco	48
Botswana	41
Indonesia	39
Mexico	38
Egypt	38
Jordan	32
Peru	32

[illegible] Institute for Resource Development/Macro International and Demographic and Health Surveys and World Health Organization

50 countries not yet acting on iodine problem

More than 50 developing countries are still not protecting their populations against the iodine deficiency disorders that are the world's biggest cause of mental retardation.

In total, about 1 billion people are at risk. About 6 million suffer from cretinism and many millions more are living below their physical and mental potential. Most vulnerable are pregnant women. The children of iodine-deficient mothers can be born as cretins – stunted, listless, mentally retarded, or incapable of normal speech, movement, and hearing. An estimated 50 million children in the developing world are unable to take full advantage of education because of iodine deficiency.

The solution is inexpensive. Iodine deficiency disorders (IDD) can be eliminated by iodizing all salt. The cost is approximately 5 cents per person per year.

The goal of eliminating IDD in this decade was accepted by a majority of the world's political leaders at the 1990 World Summit for Children.

A number of countries are now moving to bring the problem under control. Ecuador and Tanzania have made good progress and Bhutan and Bolivia are on the verge of preventing any new cases of IDD. By 1995, both China and India could be producing enough iodized salt for their entire populations.

The tables below tell the story of where IDD is still a major problem and what is being done about it. Bold type indicates those countries where national surveys show that the problem is severe – with at least 30% of school-aged children having goitre (enlargement of the thyroid gland, caused by iodine deficiency).

No recent IDD assessment or national control programme

Afghanistan	Djibouti	Libya	**Swaziland**
Angola	Equatorial Guinea	**Mongolia**	**Tunisia**
Comoros	**Gabon**	**Morocco**	**Uganda**
Côte d'Ivoire	**Lebanon**	**Somalia**	**Yemen**

Assessment and plans exist: control programme not fully operational

Benin	**Ghana**	Madagascar	**Sierra Leone**
Botswana	Guatemala	**Mali**	**Sudan**
Burkina Faso	**Guinea**	**Mozambique**	Togo
Cambodia	Guinea-Bissau	Myanmar	Zaire
C. African Rep	Iran	**Niger**	**Zambia**
Chad	**Iraq**	**Nigeria**	**Zimbabwe**
El Salvador	Lao Rep	**Paraguay**	
Ethiopia	Lesotho	**Rwanda**	
Gambia	**Liberia**	Senegal	

National control programme fully operational

Algeria	China	Malawi	Philippines
Bangladesh	Congo	**Namibia**	Sri Lanka
Bhutan	Ecuador	**Nepal**	**Syria**
Bolivia	India	Pakistan	**Tanzania**
Burundi	Indonesia	Papua New Guinea	Thailand
Cameroon	Kenya	**Peru**	**Viet Nam**

[illegible] countries where national surveys show that the problem is severe – with at least 30% of school-aged children having goitre (enlargement of the thyroid gland, caused by iodine deficiency).

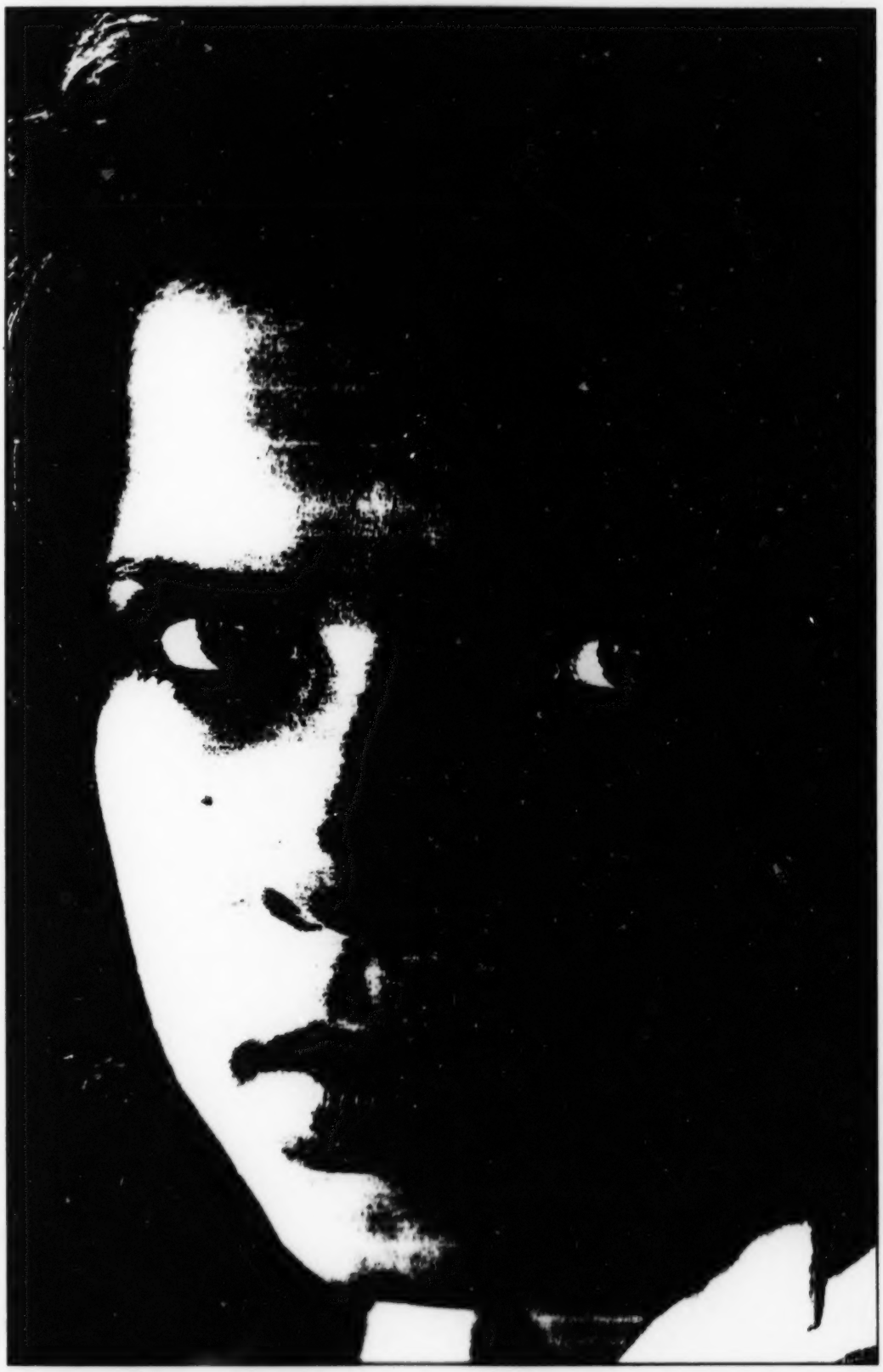
HEALTH

A SUMMARY

For the first time, the benefits of a major medical advance have been brought not just to the few but to the great majority of the world's families.

Following success in reaching 80% immunization by 1990, new goals have now been set for the year 2000.

If reached, they will bring affordable solutions to bear on the three or four most important child health problems in the developing world. Taken together, they could halve child deaths and child malnutrition by the end of this century.



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Closing the gap between knowledge and need

The following pages record the progress of nations in one very specific area of health care – immunization against measles.

Measles vaccine is one of the most vital of medical interventions in its own right; but it is also a barometer of a nation's commitment to the task of bringing the most obvious and basic medical advances to the majority of its population.

The importance of immunization against measles is widely underestimated. It saves an estimated 1.6 million children's lives a year. But it also prevents an estimated 50 million non-fatal cases of a disease which is now known to be a cause of subsequent pneumonia, diarrhoeal disease, vitamin A loss, deafness, blindness, and malnutrition.

Outreach

The battle against measles in the last decade has been part of a wider war on vaccine-preventable disease. And the achievement of the 80% immunization goal has demonstrated two propositions which hold out the hope of further significant advances in child health.

First, it has demonstrated that the outreach capacity now exists, in almost all countries, to bridge the gap between large-scale problems and low-cost solutions. For the first time, the benefits of a major medical advance have been made available not to the few but to the vast majority of families in all countries. Advances in vaccine technology have helped to make this possible. But the delivery of those vaccines to 100 million infants, on four or five separate occasions each year, is essentially a breakthrough in outreach on an unprecedented scale.

Second, the immunization achievement has demonstrated the usefulness of quantifiable, well-publicized targets. A clear and widely accepted goal has proved invaluable in mobilizing the public and political support that is necessary if available solutions are to be put into action on the same scale as the problems. Targets provide a focus for national efforts and for international support.

Largely as a result of the immunization success, the 1990 World Summit for Children accepted a range of new health goals for the year 2000 (see page 4). Almost all the world's governments have now made a formal commitment to these goals and many have drawn up specific plans for achieving them by the end of this decade.

The new health goals are more than a list of desirables. They represent a comprehensive programme for narrowing the gaps between the availability of low-cost technologies and their widespread application.

The most obvious of those gaps is the fact that two thirds of the estimated 13 million child deaths in the world each year are caused by five common diseases which medical science has long known how to prevent or treat.

Ending polio

Three of those diseases can be prevented by vaccines, as can the polio which still strikes 100,000 children each year. The fact that measles, whooping cough, and neonatal tetanus are still killing almost 2 million children a year shows that, despite recent successes, the immunization gap remains to be closed. The new goals therefore call for an increase in immunization coverage to 90% or more in all developing countries. Twelve developing countries have already reached that year 2000 target for immunization against measles (see page 25). Targets have also been announced for individual diseases: the eradication of polio; the elimination of neonatal tetanus; a 90% reduction in measles cases; and a 95% reduction in measles deaths.

Pneumonia

Probably the largest of today's gaps between what science knows and what people need is the gap between the availability of low-cost antibiotics and the deaths of the 3.6 million children who are killed each year by respiratory infections, mainly pneumonia. The majority of those lives could be saved if parents were informed about the danger signs, and if community health workers were trained to diagnose pneumonia, prescribe antibiotics, and recognize the small minority of emergency cases that need to be urgently transferred to hospital.

Over 60 developing countries now have national programmes to put these strategies into effect. The goal for the year 2000 is to reduce deaths from pneumonia by at least one third.

One in three

Close behind pneumonia as the leading cause of child death in the developing world are the diarrhoeal diseases which claim an estimated 3 million children's lives each year. And here too there is a gap to be closed between the problem and an available low-cost solution. More than half of all deaths from diarrhoeal disease are caused by dehydration which can in almost all cases be prevented by oral rehydration therapy (ORT). Almost unknown outside the scientific community a decade ago, ORT is now being used by one family in three in the developing world, and is estimated to be saving over a million lives a year. But there is still a long way to go, both in promoting ORT and in informing all parents about ways to prevent diarrhoeal disease and reduce its impact on the nutritional health of children. The year 2000 goals call for a halving of child deaths caused by diarrhoea, and a 25% reduction in the incidence of diarrhoeal disease.

Water and sanitation

Clean water supply and safe sanitation for all families is the most difficult of the goals adopted for the year 2000. But its achievement would advance virtually every other effort to improve human health. Recent advances in technology and strategy have brought this goal nearer; the cost of sinking a borehole and installing a handpump, for example, has fallen by up to 75% in recent years, and community-based strategies have brought the recurring costs of water supply as low as $2.00 per person per year. In water and sanitation too, the task is therefore one of closing the gap between what can be done and what is being done.

Synergisms

The two common factors uniting the year 2000 health goals are that they are based on solutions which are available and affordable, and that they have the potential to make a major impact on one of the main causes of illness and death in young children. Taken together, they could prevent well over half of all child deaths and child malnutrition. But the combined effect would be even greater than the sum of their parts. The enemies of child health act synergistically, pulling millions of children into the downward spiral of infection and malnutrition. And the greatest reward of advancing towards a range of basic health goals lies in the breaking of this synergism.

Future editions of *The Progress of Nations* will monitor progress towards all of the major health goals for the year 2000. *–PA*

HEALTH

LEAGUE TABLE OF

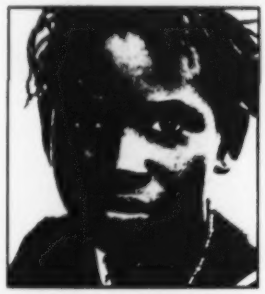
These pages rank the nations of the world by the percentage of their children vaccinated against measles.

In the mid-1980s, the goal of 80% immunization was accepted by political leaders worldwide.

Today, most developing countries have reached that goal – saving the lives of approximately 3 million children each year.

Measles immunization helps protect children against other diseases, disabilities, and malnutrition (see box facing page).

It is also a measure of the effectiveness of a nation's health services.



SUB-SAHARAN AFRICA

		%
1	Mauritius	88
2	Zimbabwe	83
3	Rwanda	81
4	Botswana	78
4	Malawi	78
6	Gabon	76
6	Lesotho	76
8	Burundi	75
8	Tanzania	75
10	Uganda	73
11	Namibia	71
12	Zambia	69
13	Congo	64
14	South Africa	63
15	Benin	60
16	Liberia	55
17	Sierra Leone	54
18	Guinea-Bissau	52
19	Togo	51
20	Mozambique	50
21	Côte d'Ivoire	47
22	Central African Rep.	46
22	Nigeria	46
22	Senegal	46
▶	*Regional average*	*46*
25	Angola	40
25	Madagascar	40
27	Ghana	39
27	Mali	39
29	Kenya	38
30	Burkina Faso	36
31	Cameroon	35
32	Guinea	33
33	Zaire	31
34	Somalia	30
35	Mauritania	29
36	Niger	23
37	Chad	21
38	Ethiopia	17

MIDDLE EAST and NORTH AFRICA

		%
1	Oman	96
2	Kuwait	93
3	Egypt	90
3	Saudi Arabia	90
5	Syria	87
6	Iran	84
7	Algeria	83
7	Jordan	83
9	Tunisia	82
10	United Arab Emirates	81
11	Morocco	80
▶	*Regional average*	*78*
12	Iraq	68
13	Turkey	66
14	Yemen	64
15	Libya	59
15	Sudan	59
17	Lebanon	51

SOUTH ASIA

		%
1	India	86
2	Bhutan	82
▶	*Regional average*	*79*
3	Pakistan	77
4	Sri Lanka	76
5	Nepal	63
6	Bangladesh	53
7	Afghanistan	29

WORLD AVERAGE

% immunized against measles

Measuring immunization

Statistics for immunization are 1991 estimates by WHO and UNICEF and are more comprehensive and up to date than for any other social indicator. This is because the effort to reach the 80% goal led to closer monitoring of progress (which in turn helped fuel the immunization surge).

The figures given here, based on vaccine use and household surveys, show coverage at age one. Before nine months, measles vaccine can be nullified by antibodies passed to the child by the mother. Thereafter, this natural protection fades, leaving the unimmunized child at risk.

In industrialized countries, where measles is less prevalent and usually less disastrous, vaccine is given at 12 to 15 months to allow natural protection to disappear. This increases the success rate of the vaccine. If measured at age two, as is the case for example in the USA, the immunization level would be significantly higher in developing countries such as Nigeria.

MEASLES IMMUNIZATION

EAST ASIA and PACIFIC

		%
1	Korea, Dem.	99
2	Korea, Rep.	96
3	China	95
4	Singapore	90
▶	*Regional average*	*89*
5	Philippines	88
5	Viet Nam	88
7	Mongolia	86
8	Malaysia	79
8	Thailand	79
10	Indonesia	78
11	Myanmar	63
12	Papua New Guinea	52
13	Hong Kong	42
14	Cambodia	34
15	Lao Rep.	20

CENTRAL AMERICA and CARIBBEAN

		%
1	Cuba	99
2	Costa Rica	90
3	Honduras	86
4	Trinidad and Tobago	81
5	Panama	80
6	Mexico	78
▶	*Regional average*	*[illegible]*
7	Dominican Rep.	69
8	Jamaica	68
9	Nicaragua	54
10	El Salvador	53
11	Guatemala	49
12	Haiti	31

SOUTH AMERICA

		%
1	Argentina	99
2	Chile	93
3	Brazil	83
3	Colombia	83
5	Uruguay	82
▶	*Regional average*	*80*
6	Paraguay	74
7	Bolivia	73
8	Venezuela	61
9	Peru	59
10	Ecuador	54

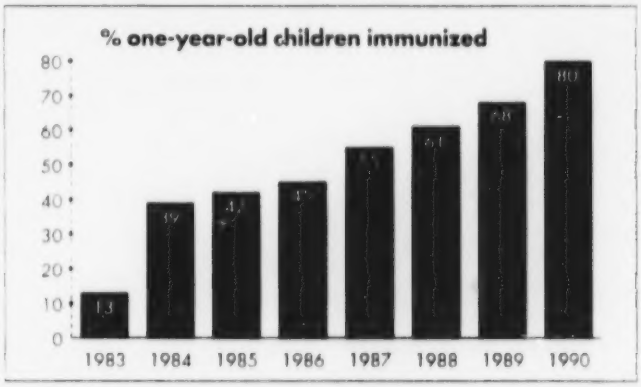
INDUSTRIALIZED COUNTRIES

		%
1	Hungary	100
2	Ireland	99
3	Czechoslovakia (former)	98
4	Bulgaria	97
4	Finland	97
6	Portugal	96
7	Sweden	95
8	Netherlands	94
8	Poland	94
10	Romania	92
11	Germany	90
11	New Zealand	90
11	Norway	90
11	Switzerland	90
15	United Kingdom	89
16	Albania	87
17	Denmark	86
17	Israel	86
19	Canada	85
20	Spain	84
▶	*Group average*	*80*
21	USA	77
22	Greece	76
23	Belgium	75
24	Japan	73
25	France	69
26	Australia	68
27	Austria	60
28	Italy	50

The rise in measles immunization

Deaths from measles have been reduced from approximately 2.5 million a year in 1980 to under 900,000 in 1990. Just as important is the massive reduction in non-fatal episodes of the disease – from about 75 million a year to about 25 million. Non-fatal attacks of measles are associated with subsequent malnutrition, pneumonia, diarrhoea, vitamin A loss, blindness, and deafness. Measles immunization is therefore probably the most important single medical intervention for protecting children against malnutrition and disease.

GLOBAL COVERAGE WITH MEASLES VACCINE, 1983-1990



TARGET

A 90% reduction in measles cases and a 95% reduction in measles deaths, compared to pre-immunization level-

FOR THE YEAR 2000

ACHIEVEMENT AND

The league tables on the previous pages show each nation's absolute level of achievement in protecting children against measles. But achievement can also be measured by the rate of progress over time, or by the level reached in relation to a country's wealth, or by the size of the task and the difficulties to be overcome.

Two nations which stand out by any and all of these measures are India and China. Fifty million babies are born into these two countries every year; 40 million of them are immunized against measles before their first birthdays.

Against all odds, Uganda leads Africa in rate of progress against measles

Fighting measles: best performances

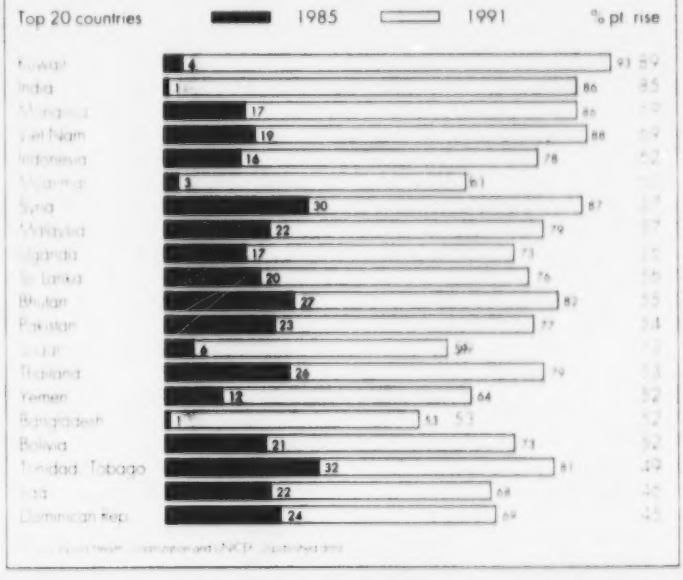
The proportion of the developing world's infants being immunized against measles has risen from 34% to 76% in the last six years. This achievement, one of the biggest success stories of the last decade, is now saving the lives of more than one and a half million children each year and helping to protect the nutritional health of millions more.

The chart shows the 20 countries with the best performances since the mid-1980s; half are countries with per capita incomes of less than $500 per year.

Kuwait and India head the list, though both started from very low levels in the mid-1980s. Uganda, moving from 17% coverage to over 70% in six years despite severe economic and logistical problems, is the one country from sub-Saharan Africa to make the list. Myanmar and Bangladesh, two of the world's poorest countries, both moved from almost zero coverage to over 50%.

Fastest progress

% of children immunized against measles (age 1 year)



Source: World Health Organization and UNICEF, unpublished data

Coverage sustained

Following the extraordinary worldwide effort to reach the target of 80% immunization by the end of 1990, it was widely feared that vaccination levels would fall back again in 1991. The latest figures show that in general this has not happened.

Measles immunization is perhaps the most difficult to sustain, but out of 127 countries for which 1991 figures are available, 45 increased the percentage of infants immunized against the disease, 49 held coverage at or close to 1990 levels, and 33 saw their rates drop by more than 5 percentage points.

In Asia's five most populous countries, with over half the developing world's children, 1990 immunization levels have been largely maintained:

Measles coverage	% 1990	% 1991
China	96	95
India	87	86
Indonesia	86	78
Pakistan	75	77
Bangladesh	54	53

Falling coverage

The countries which saw a fall of 10 percentage points or more in measles immunization levels between 1990 and 1991 were:

	% 1990	% 1991	% pt. fall
Central African Rep.	82	46	36
Nicaragua	82	54	28
Dominican Rep.	96	69	27
El Salvador	75	53	22
Sierra Leone	75	54	21
Kenya	59	38	21
Ghana	60	39	21
Cameroon	56	35	21
Ethiopia	37	17	20
Panama	99	80	19
Guatemala	68	49	19
Australia	85	68	17
Papua New Guinea	67	52	15
Senegal	59	46	13
Malaysia	90	79	11
Libya	70	59	11
Congo	75	64	11
Chad	32	21	11
Benin	70	60	10

Source: World Health Organization and UNICEF, unpublished data

BEST COPY AVAILABLE

DISPARITY

A moment's pain, a lifetime's protection – China reaches 95%

Twelve countries reach year 2000 goal

Twelve developing countries have already reached the year 2000 goal of immunizing 90% of their children against measles. They include China, which has almost 20% of the world's children.

The new target of 90% is more than just a marginal improvement on the earlier 80% goal. Because measles is particularly virulent, vaccination levels must reach well over 90% to have a major impact on reducing disease transmission. It is also important to push coverage to the highest possible level in order to protect the poorest 20% of children who are most vulnerable to the disease and among whom it takes its heaviest toll on life, health, and normal growth.

The countries that have met the 90% measles immunization goal are:

	% immunized 1991
Argentina	99
Cuba	99
Korea, Dem	99
Korea, Rep	96
Oman	96
China	95
Chile	93
Kuwait	93
Costa Rica	90
Egypt	90
Saudi Arabia	90
Singapore	90

Source: World Health Organization and UNICEF, unpublished data

Some poorer countries have better record

Ten of the world's poorest countries have reached the 80% target for measles immunization. They include the two largest nations in the world, India and China, which are home to 40% of the developing world's children. Every year, approximately 50 million babies are born into these two countries; 40 million of them are now being protected by measles vaccine. Two other countries that have reached the 80% target, Bhutan and Viet Nam, are among the least developed nations of the world.

By contrast there are 13 countries where per capita incomes are more than twice as high but where protection of children against measles falls short of the 80% mark.

In the industrialized world, where later vaccination schedules make higher coverage less difficult, the average level of measles immunization is lower than in East Asia.

Italy and Hong Kong have vaccination levels as low as 50% – approximately the same as in sub-Saharan Africa.

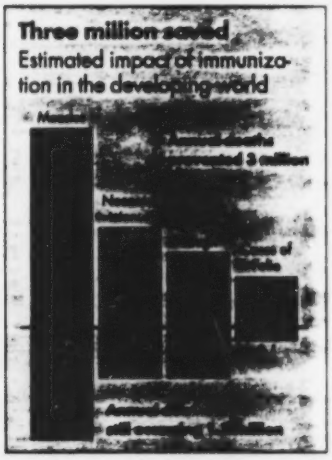
Poorer countries on target...
Per capita GNP less than $1000, measles coverage more than 80%

	Per capita GNP ($)	% immunized 1991
Korea, Dem	970	99
China	370	95
Egypt	620	90
Philippines	740	88
Viet Nam	240	88
Honduras	570	86
India	330	86
Mongolia	780	86
Zimbabwe	620	83
Bhutan	180	82

Richer falling short...
Per capita GNP more than $2000, measles coverage less than 80%

	Per capita GNP ($)	% immunized 1991
Mexico	2870	78
USA	22560	77
Greece	6230	76
Belgium	19300	75
Japan	26920	73
France	20600	69
Australia	16590	68
South Africa	2530	63
Venezuela	2610	61
Austria	20380	60
Lebanon	2150	51
Italy	18580	50
Hong Kong	13200	42

Source: GNP, World Bank, World Bank Atlas 1993; immunization, World Health Organization and UNICEF, unpublished data



The immunization achievement

Progress against measles is part of a wider effort to vaccinate infants against major childhood diseases. The chart shows the overall impact in lives saved and disabilities prevented.

The scale of achievement cannot be overestimated. In countries where transport, power supplies, and health services are often inadequate, vaccines are being delivered at the right time and the right temperature to over 100 million children on four or five separate occasions in their first year. Creating demand is as important as ensuring supply, and many thousands of individuals and organizations have been involved in one of the largest peacetime operations in history.

Few countries have gone against the worldwide trend towards rising vaccine coverage. Since the mid-1980s, only ten nations have registered a fall of 5 percentage points or more in measles immunization.

In some, but not all, the cause has been military, economic or political upheaval.

Bucking the trend
Ten countries with a six-year fall in measles coverage

	1985	1991	% pt fall
Hong Kong	80	42	-38
Mauritania (1984–1991)	59	29	-30
Kenya	63	38	-25
Ghana (1986–1991)	63	39	-24
El Salvador	71	53	-18
Belgium	90	75	-15
Lao Rep	33	20	-13
Zaire	40	31	-9
Albania	96	87	-9
Somalia	35	30	-5

Source: World Health Organization and UNICEF, unpublished data

EDUCATION

A SUMMARY

After decades of rapid progress, primary education is in crisis.

Spending has been cut back. Policy and strategy are in the doldrums. Progress towards universal primary education is faltering.

Enrolment remains high almost everywhere. The problem is not getting children into schools, it is keeping them there. Almost half leave before completing four years.

Brave new approaches are being tried out. But whatever solutions are found, they must eventually become the responsibility of governments if they are to be put into action on the same scale as the problems.

Schools weighed and found wanting

The tables on the following pages show the progress of nations towards the goal of primary education for all. The criterion used is the percentage of children reaching grade 5. Four years of school may not be enough to establish literacy, nor does it signify the completion of primary education, but given the available statistics this is the one common standard by which national achievements can be compared.

Overall, the proportion of the developing world's children enrolled in primary school has risen by two thirds in 30 years, from 48% in 1960 to 78% in 1990. Given that the actual number of children has almost doubled over that same period, this is an enormous achievement. But that is where the good news ends. For after decades of rapid progress, primary education is in crisis.

Spending cuts

The crisis has been brought about primarily by cut-backs in educational expenditures during the 1980s. Under pressure of debt and falling raw material prices, many governments have been forced to make spending cuts. Military expenditures have suffered a little. Health and education expenditures have suffered a lot. "In nearly half the developing countries," said the Director-General of UNESCO at the end of the decade, "the goal of universal primary education is receding rather than drawing nearer."

The chart on page 28 shows at a glance where the heart of the problem lies: enrolment in grade 1 of primary education remains high in every region, but up to half of those who start school drop out before completing four years. If educational progress is to be reaccelerated, then the clear priority is to ensure that children remain in school long enough to acquire literacy, numeracy, and basic attitudes and skills which will help them to improve their own and their families' circumstances.

There are many reasons for dropping out of school. But the underlying reason is usually that parents or children, or both, decide that the effort and cost of staying at school are not matched by the quality of, or likely benefits from, the education being offered.

A poor family may be hard pressed to meet the incidental costs of school clothes, books, equipment, meals, bus fares, and donations to school funds. Perhaps the family needs the child's help in the fields or the home; perhaps there are no employment opportunities for the educated; perhaps the last school report was poor and the child seems uninterested; perhaps the prevailing view is that a girl does not really need to go to school in order to become a wife and mother. Whatever the circumstances, the benefits of education must be perceived as real if they are to outweigh such costs and considerations. But as investment in education declines, as teachers' salaries go unpaid, as books and equipment are worn out and not replaced, and as jobs in the modern sector become harder to find, the perceived benefits grow less substantial. Every day, thousands weigh education in the scale and find it wanting.

The best investment

No one disagrees that education is fundamental to development. Japan, Singapore, and the Republic of Korea are sufficient evidence. "It is no exaggeration to say," Japan's Prime Minister told the 1990 World Summit for Children, "that the policy of promoting education constituted the very foundation of Japan's development." Studies have shown that education helps to replace resignation with a degree of confidence, acceptance with an awareness of choice. In recent years, a strong correlation has been established between education and later marriage, smaller family size, and improvements in the health, nutrition, and survival of children.

But for all the agreement about the importance of primary education, in many regions the progress of the 1960s and 1970s seems to have stalled. Resources have dried up, and policy and strategy are in the doldrums.

Resources are only part of the answer. But primary schools in most countries clearly need more investment. There are two main ways in which extra resources might be found. The first involves a degree of restructuring in government expenditures, allocating a higher proportion to education and tipping the balance towards the primary schools. In Pakistan, as in many other nations, two thirds of the education budget is spent on secondary and higher education while only one third of children complete primary school.

A second potential source is overseas aid. But to help primary education, aid too would have to be reshaped. At the moment less than 1% of total aid goes into primary education.

Lessons for schools

As progress has stagnated, attempts have been made to find the educational equivalents of the strategies which have begun to make breakthroughs towards universal primary health care (see page 21). In that search, much attention has been focused on the achievements of one particular non-governmental organization – the Bangladesh Rural Advancement Committee (BRAC).

In eight years, BRAC has opened over 10,000 schools, mainly for children of the poor and the landless. Most of its pupils either never started formal schooling or dropped out at an early stage. The BRAC schools provide three years of basic education, including literacy, numeracy, and social studies, for an approximate cost of $15 per pupil per year. Classes are small, and the timetable and school year fit in with the demands of the agricultural calendar. So far, over 90% of BRAC's pupils have graduated back into the national primary education system.

But the total number of pupils in BRAC's 10,000 schools amounts to under 2% of the primary-school-age population of Bangladesh. In the developing world as a whole, almost 100 million children a year start primary school. The task is to keep them there. And such is the scale of this challenge that there is no realistic substitute for a system of universal primary education provided primarily by governments. The relevance of the BRAC venture is therefore not as an alternative system, but as a guide to making national primary education systems work better.

Para-teachers

Central to BRAC's success are the twin ideas of para-teachers and community involvement. In BRAC schools, parents are involved in putting up classrooms, selecting educated members of the community to be teachers, discussing matters of syllabus and timetable, and achieving a better fit between school and the realities of children's lives and expectations. Para-teachers, recruited locally from among the educated and the 'good-with-young-children', can be quickly trained in today's methods of stimulating eagerness to learn in the very young. More qualified teachers can then be freed for more advanced work in literacy and numeracy.

A ferment of similar experiments will be needed to find the paths to education down which a new generation of children might march. But ultimately, new approaches and ideas must become the responsibility of governments, as well as communities, if the problems of primary education are to be addressed on the necessary scale. – *PA*

EDUCATION

LEAGUE TABLE OF

These pages rank all countries by the percentage of their children reaching grade 5 of primary education.

Over 90% of the developing world's children start school. But in many countries, half drop out in the first few years.

As a result, there are now an estimated 100 million children aged 6 to 11 not in school. Two thirds of them are girls.

Grade 5 enrolment indicates the percentage of children who are completing at least four years of primary school – the minimum required if a child is to receive even a basic education.

SUB-SAHARAN AFRICA

		%
1	Zimbabwe	94
2	Mauritius	89
3	Ghana	74
4	Cameroon	73
5	Congo	72
6	Kenya	71
7	Namibia	70
7	Togo	70
9	Botswana	66
10	Zambia	61
11	Nigeria	59
11	Rwanda	59
11	Zaire	59
14	Côte d'Ivoire	58
15	Burundi	57
15	Lesotho	57
17	Senegal	52
18	Gabon	50
▶	*Regional average*	*48*
19	Chad	45
20	Central African Rep.	44
21	Benin	41
22	Mauritania	39
23	Mozambique	35
24	Angola	34
24	Madagascar	34
26	Malawi	31
27	Burkina Faso	29
28	Guinea	25
28	Guinea-Bissau	25
30	Tanzania	24
31	Niger	23
32	Mali	18
33	Ethiopia	17
34	Somalia	2
	Liberia	NO DATA
	Sierra Leone	NO DATA
	South Africa	NO DATA
	Uganda	NO DATA

MIDDLE EAST and NORTH AFRICA

		%
1	Turkey	97
1	United Arab Emirates	97
3	Algeria	95
4	Syria	94
5	Jordan	92
6	Iran	91
6	Oman	91
8	Tunisia	87
9	Kuwait	83
▶	*Regional average*	*81*
10	Egypt	75
11	Iraq	72
12	Saudi Arabia	68
13	Morocco	60
14	Sudan	44
	Lebanon	NO DATA
	Libya	NO DATA
	Yemen	NO DATA

SOUTH ASIA

		%
1	Sri Lanka	91
2	India	53
▶	*Regional average*	*50*
3	Bangladesh	47
4	Pakistan	37
5	Afghanistan	25
6	Bhutan	12
	Nepal	NO DATA

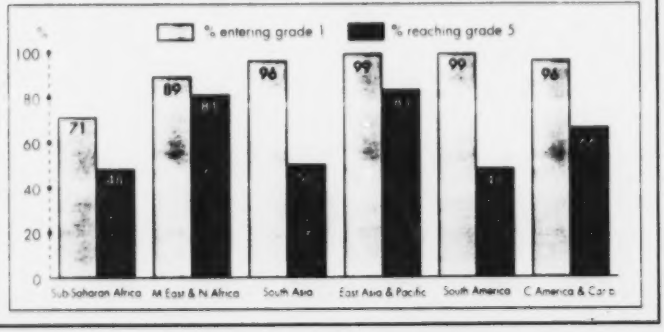
WORLD AVERAGE

% of children reaching grade 5

Enrolment and retention

The chart shows that the percentage of children reaching grade 5 is determined by both enrolment and retention. Sub-Saharan Africa has the same proportion reaching grade 5 as South America, but achieves this by retaining a higher proportion of a smaller intake.

SOURCE UNICEF calculations from data supplied by UNESCO, mostly for 1988 to 1990



PRIMARY EDUCATION

EAST ASIA and PACIFIC

		%
1	Singapore	100
2	Hong Kong	99
3	Korea, Rep.	90
4	Malaysia	86
5	China	85
6	Indonesia	83
▶	*Regional average*	*83*
7	Philippines	75
8	Thailand	63
9	Papua New Guinea	53
10	Lao Rep.	22
	Cambodia	NO DATA
	Korea, Dem.	NO DATA
	Mongolia	NO DATA
	Myanmar	NO DATA
	Viet Nam	NO DATA

CENTRAL AMERICA and CARIBBEAN

		%
1	Jamaica	96
2	Cuba	90
3	Costa Rica	84
4	Panama	82
5	Mexico	76
6	Trinidad and Tobago	72
▶	*Regional average*	*66*
7	Honduras	48
8	Dominican Rep.	46
9	El Salvador	45
10	Nicaragua	44
11	Guatemala	41
12	Haiti	12

SOUTH AMERICA

		%
1	Uruguay	96
2	Chile	75
3	Ecuador	67
3	Paraguay	67
5	Bolivia	60
6	Colombia	55
▶	*Regional average*	*48*
7	Brazil	41
	Argentina	NO DATA
	Peru	NO DATA
	Venezuela	NO DATA

INDUSTRIALIZED COUNTRIES

		%
1	Australia	100
1	Finland	100
1	Japan	100
1	Sweden	100
5	Denmark	98
5	Germany	98
5	Norway	98
8	France	97
8	Spain	97
10	Canada	96
10	Ireland	96
10	Poland	96
10	USA	96
▶	*Group average*	*96*
14	Czechoslovakia (former)	94
14	Greece	94
14	Hungary	94
14	Israel	94
14	Netherlands	94
19	Italy	89
20	Bulgaria	88
21	New Zealand	82
22	Belgium	81
23	Romania	79
	Albania	NO DATA
	Austria	NO DATA
	Portugal	NO DATA
	Switzerland	NO DATA
	United Kingdom	NO DATA

Schooling target met by some poor nations

Four very poor countries (GNP per capita below $1000) have already achieved the target of providing 80% of their children with at least four years of schooling. Zimbabwe has achieved remarkably rapid progress; at the time of independence in 1980, only about one third of its children were completing primary school.

	GNP per capita 1991($)	% children reaching grade 5
Zimbabwe	620	94
Sri Lanka	500	91
China	370	85
Indonesia	610	83

Six more countries with per capita incomes of less than $1000 are providing primary education for more than 70% of all their children and have an excellent chance of reaching the 80% goal before the end of the century.

	GNP per capita 1991($)	% children reaching grade 5
Egypt	620	75
Philippines	740	75
Ghana	400	74
Cameroon	940	73
Kenya	340	71
Togo	410	70

Eleven countries with per capita GNPs of more than $1000 have not yet achieved 80% primary education.

	GNP per capita 1991($)	% children reaching grade 5
Brazil	2920	41
El Salvador	1070	45
Gabon	3780	50
Colombia	1280	55
Morocco	1030	60
Thailand	1580	63
Botswana	2590	66
Paraguay	1210	67
Ecuador	1020	67
Saudi Arabia	7050	68
Romania	1340	79

SOURCES: GNP: World Bank, *World Bank Atlas*, 1992. Grade 5 enrolment: UNICEF calculations from UNESCO data.

TARGET

A basic education for all children and completion of primary school by at least 80%.

FOR THE YEAR 2000

FAMILY PLANNING

A SUMMARY

Approximately one pregnancy in five in the developing world is unwanted and unplanned.

Meeting this demand for family planning could reduce maternal mortality and abortion rates. prevent far more than 20% of all child deaths. and improve the health and nutrition of many millions of women and children. It could also ease the pressure on one of the world's most over-exploited resources - the time and energy of women.

In addition. making family planning available to all couples could bring about a further significant slowing down of population growth.

A suitable case for prevention

The league tables on the following pages list all nations according to their average number of births per woman. They are therefore a guide to the progress that each country is making in the transition towards smaller families and the eventual stabilization of populations. Broadly speaking, the tables show that family size tends to fall as income rises. But this pattern is far from consistent, and it is clear that other forces also have a powerful effect on fertility levels. The most important of these forces are rising female literacy, falling child death rates, and the availability of family planning services. The first two of these are discussed elsewhere in *The Progress of Nations*. This introduction concentrates on the family planning factor.

Benefits for women

The 1990 World Summit for Children called for family planning education and services to be made available to all couples by the end of this decade. As more is learned about the benefits of planning and spacing births, the case for an all-out effort to reach this goal grows stronger. And it is a case that can be made without reference to the problems of population growth or environmental degradation.

❍ Family planning could save the lives of hundreds of thousands of women each year. At present, an estimated 500,000 women die annually from the complications of pregnancy and giving birth. About 20% of those pregnancies and births are unplanned and unwanted. And as most unwanted births fall into the high-risk category, family planning could prevent a disproportionately large number of maternal deaths.

❍ Family planning could also drastically reduce the toll of unsafe abortion. Approximately 50,000 illegal abortions are performed every day in the developing world and about 100,000 women die every year as a result.

❍ Family planning can improve the overall quality of life for women in the developing world, just as it has done for women in the industrialized world. It can help to prevent the 'maternal depletion' caused by having too many children and too little recovery time in between. It can reduce the anaemia that afflicts half of the developing world's women.

It can allow girls to mature physically and emotionally before they become mothers. It can allow girls to complete their education or training. It can allow women more time for enjoying their children, for earning incomes, for community activities, and for the rest and recreation that is today almost entirely denied to millions of women in the developing world.

Benefits for children

❍ Family planning could save the lives of several million children each year. A large share of the births prevented by family planning would be high-risk births – babies born within two years of a previous birth, or born to women who already have four or more children, or to women who are younger than 18 or older than 35. Reducing the number of these high-risk births, estimated at between a quarter and a third of all births, would prevent a disproportionate number of child deaths.

❍ Family planning could improve the nutritional health of many millions of children.

Too frequent child-bearing is one of the most important causes of malnutrition in almost every country. The average interval between births is strongly correlated with the incidence of low birth weight, which in turn is strongly associated with poor nutritional health not only in infancy but throughout the early years of childhood. Spacing births means that mothers have more time for breastfeeding and weaning. A major reason for malnutrition and illness in the young child is the ending of breastfeeding; and a major reason for the ending of breastfeeding is the onset of another pregnancy.

❍ Nutritional health may also be affected in other ways. In almost all developing countries women grow, store and prepare most of the family's food. Too frequent child-bearing means that women have less of the time and energy that such work demands – and the attempt to cope with so much work leaves women permanently exhausted.

Family planning is therefore a many-faceted means of improving the nutritional health of the mother, her young children, and the family as a whole.

❍ Family planning can also help to reduce illness. Overcrowding in the home, especially in the context of poverty, helps to spread measles, diarrhoeal disease and pneumonia – the three most common causes of illness and death among the world's children.

❍ The means of preventing or treating the most common illnesses of childhood – including breastfeeding, oral rehydration therapy, better weaning, hand-washing, and the safe preparation and storage of food – all require time. Family planning can enable the mother to give that time.

Quality of care

In all of these specific ways, family planning can improve the quality of life for children. But it also offers many less quantifiable benefits. Most mothers know that a young child requires a great deal of work and attention if he or she is to be safe, healthy, and well-nourished, and to develop into an intelligent, self-confident, and happy child. Family planning enables mothers to give that time and attention. Another pregnancy and another birth, on the other hand, deprives the very young child of all the detailed attention he or she still needs. Family planning can also bring benefits to older girls and boys. All other things being equal, the quality of child care tends to rise as parents invest their time, energy, and money in bringing up a smaller number of children. More than any other single factor, family planning can therefore advance the progress of nations towards the goals that have been internationally accepted for the year 2000. It is a strategy not just for population control but for better standards of health, nutrition, education, housing and material improvement.

One billion less

In addition to all of these arguments, making family planning available to all is essential if population growth is to be slowed further, if the pressure on the earth's resources and ecosystems is to stay within manageable limits, and if sustainable development is to be achieved in the 21st century. Finally, it has become clear in recent years that significant demand for family planning already exists. Approximately one out of five pregnancies in the developing world is unwanted. If the existing demand could be met, if women could choose how many children to have and when, then in addition to all the advantages for women and children there would be a reduction of one third in population growth. In only 35 years from now, this would mean about one billion fewer people.

The extra resources needed to reach the goal of making family planning available to all couples by the end of this century would amount to approximately $2.5 billion a year. When so much could be achieved for so many and at so little cost – and at such benefit to the planet as a whole – failure to make family planning available to all couples may well come to be regarded as the 20th century's most costly mistake. – *PA*

FAMILY PLANNING

LEAGUE TABLE OF

These pages rank all countries by their average number of births per woman (total fertility rate or TFR).

The TFR has a profound influence on the well-being of mothers and children. Too many births too close together, or at too young or too old an age, is a major cause of illness, disability, poor nutrition, and premature death among both women and children.

Fewer births can bring drastic improvements to the lives of women. It can also improve child survival, nutrition, health, and education – and allow parents to invest their energy, time, and money in a smaller number of children.

SUB-SAHARAN AFRICA

1	Mauritius	2.0
2	South Africa	4.2
3	Lesotho	4.8
4	Botswana	5.2
5	Zimbabwe	5.5
6	Cameroon	5.8
7	Ghana	6.1
8	Central African Rep.	6.2
8	Senegal	6.2
10	Congo	6.3
11	Kenya	6.4
12	Mauritania	6.5
12	Mozambique	6.5
▶	*Regional average*	*6.5*
14	Madagascar	6.6
14	Togo	6.6
16	Zaire	6.7
17	Burundi	6.8
17	Liberia	6.8
17	Tanzania	6.8
20	Ethiopia	7.0
20	Somalia	7.0
22	Benin	7.1
22	Mali	7.1
24	Angola	7.2
25	Uganda	7.3
26	Côte d'Ivoire	7.4
27	Malawi	7.6
28	Rwanda	8.5
	Burkina Faso	NO DATA
	Chad	NO DATA
	Gabon	NO DATA
	Guinea	NO DATA
	Guinea-Bissau	NO DATA
	Namibia	NO DATA
	Niger	NO DATA
	Nigeria	NO DATA
	Sierra Leone	NO DATA
	Zambia	NO DATA

MIDDLE EAST and NORTH AFRICA

1	Lebanon	3.2
2	Tunisia	3.6
2	Turkey	3.6
4	Kuwait	3.8
5	Egypt	4.2
6	Morocco	4.5
7	United Arab Emirates	4.6
8	Algeria	5.0
▶	*Regional average*	*5.0*
9	Iraq	5.8
9	Jordan	5.8
11	Iran	6.1
12	Sudan	6.2
13	Syria	6.3
14	Libya	6.5
14	Saudi Arabia	6.5
16	Oman	6.8
17	Yemen	7.3

SOUTH ASIA

1	Sri Lanka	2.5
2	India	4.0
▶	*Regional average*	*4.4*
3	Bangladesh	4.8
4	Nepal	5.6
5	Bhutan	5.9
6	Pakistan	6.3
	Afghanistan	NO DATA

WORLD AVERAGE

Births per woman

Total fertility rates

The total fertility rate (TFR) is the average number of births per woman. Assuming no child deaths, a TFR of 2.0 means that each couple is reproducing itself. Once this replacement level has been reached, the population will eventually stabilize.

But rapid population growth has left developing nations with disproportionate numbers in their child-bearing years; this means that populations will continue to grow for some time even after replacement level is reached. In Mexico, for example, the average number of births per woman has fallen by 50% in 30 years, but the actual number of births each year has increased by 50%.

Statistics on TFR come mainly from censuses and household surveys and have much in common with the data on child deaths. But because birth is much more common than child death, a smaller sample size can be used and the quality of TFR data is therefore generally better.

For further information see United Nations, *World population prospects*, 1992 revision.

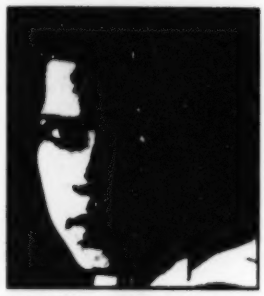
BIRTHS

EAST ASIA and PACIFIC

1	Hong Kong	1.4
2	Korea, Rep.	1.7
2	Singapore	1.7
4	China	2.3
4	Thailand	2.3
6	Korea, Dem.	2.4
▶	*Regional average*	*2.6*
7	Indonesia	3.2
8	Malaysia	3.7
9	Philippines	4.0
9	Viet Nam	4.0
11	Myanmar	4.3
12	Cambodia	4.5
13	Mongolia	4.7
14	Papua New Guinea	5.0
15	Lao Rep.	6.7

CENTRAL AMERICA and CARIBBEAN

1	Cuba	1.9
2	Jamaica	2.5
3	Trinidad and Tobago	2.8
4	Panama	3.0
5	Costa Rica	3.2
6	Mexico	3.3
7	Dominican Rep.	3.5
▶	*Regional average*	*3.5*
8	El Salvador	4.2
9	Haiti	4.9
10	Honduras	5.1
11	Nicaragua	5.2
12	Guatemala	5.5



SOUTH AMERICA

1	Uruguay	2.4
2	Chile	2.7
2	Colombia	2.7
4	Argentina	2.8
5	Brazil	2.9
▶	*Regional average*	*3.0*
6	Venezuela	3.2
7	Peru	3.7
8	Ecuador	3.8
9	Paraguay	4.4
10	Bolivia	4.7

INDUSTRIALIZED COUNTRIES

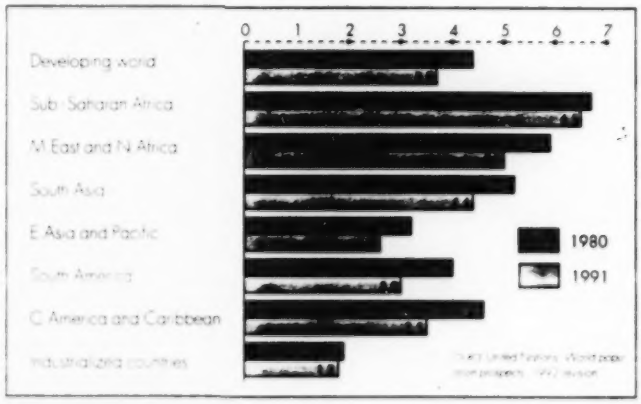
1	Italy	1.3
2	Spain	1.4
3	Austria	1.5
3	Germany	1.5
3	Greece	1.5
3	Portugal	1.5
7	Belgium	1.6
7	Switzerland	1.6
9	Denmark	1.7
9	Japan	1.7
9	Netherlands	1.7
12	Canada	1.8
12	Finland	1.8
12	France	1.8
12	Hungary	1.8
▶	*Group average*	*1.8*
16	Australia	1.9
16	Bulgaria	1.9
16	Norway	1.9
16	United Kingdom	1.9
20	Czechoslovakia (former)	2.0
20	Sweden	2.0
20	USA	2.0
23	New Zealand	2.1
23	Poland	2.1
25	Ireland	2.2
25	Romania	2.2
27	Albania	2.8
28	Israel	2.9

Declining birth rates

The average number of births per woman in the developing world has fallen steeply in the last decade. In South America the average number of children has fallen from 4 to 3 in ten years. In South Asia, fertility has fallen from just over 5 births per woman in 1980 to just over 4 in 1991. East Asia, dominated in population size by China, is nearing the replacement level of just over 2 births per woman. Sub-Saharan Africa has seen little change in fertility over the last ten years – but the most recent surveys suggest a definite downturn.

FALLING FERTILITY

Regional total fertility rates, 1980 and 1991



TARGET

Family planning education and family planning services to be made available to all couples.

FOR THE YEAR 2000

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Fertility rates are now declining in all regions of the developing world.

But rapid population growth in the past has left most countries with disproportionate numbers of people in their reproductive years. So the absolute number of births is still rising, even though average family size is falling.

By about the year 2000, the annual number of births in the developing world will have reached its peak.

If women could choose how many children to have and when, population growth would stabilize at a lower level.

FAMILY PLANNING

ACHIEVEMENT AND

Colombia and El Salvador – one child less

Steep fall in family size

Average family size is falling steeply in almost all regions of the developing world.

Previously, sub-Saharan Africa has stood out against the trend. But evidence from recent surveys, not yet incorporated into official UN estimates, suggests that in Africa, too, fertility may now be making a downward turn.

Throughout most of Asia and Latin America, family size is falling at a far faster rate than was achieved by today's industrialized countries. Seventeen nations, including the most populous Latin American countries, Brazil and Mexico, have reduced the average number of births per woman by half or more in one generation (see table). In the last decade alone, births per woman have fallen by one child or more in 21 nations. The steepness of these falls in fertility is unprecedented in demographic history.

Sixteen of the 20 countries with the highest fertility rates in the world are in sub-Saharan Africa, where the average woman gives birth to over six children. Even in Africa a turning-point may now have been reached.

None of the 20 nations with the world's highest fertility rates, with the exception of Saudi Arabia, has seen any significant change in average family size over the last ten years (see table).

Family size halved
Where births per woman have been halved in one generation

	Average no. of births		
	1960	1991	% fall
Korea Rep	5.7	1.7	70
Singapore	5.5	1.7	69
Mauritius	5.9	2.0	66
Thailand	6.4	2.3	64
China	5.7	2.3	60
Korea Dem	5.8	2.4	59
Cuba	4.2	1.9	55
Costa Rica	7.0	3.2	54
Jamaica	5.4	2.5	54
Albania	5.9	2.8	53
Brazil	6.2	2.9	53
Canada	3.8	1.8	53
Dominican Rep	7.4	3.5	53
Mexico	6.8	3.3	52
Portugal	3.1	1.5	52
Venezuela	6.0	2.9	52
Spain	2.8	1.4	50

One child less
Where births per woman have fallen by one child or more in the last decade

	Average no. of births		
	1980	1991	Diff.
Algeria	6.8	5.0	-1.8
Tunisia	5.3	3.6	-1.7
Bangladesh	6.4	4.8	-1.6
Botswana	6.8	5.2	-1.6
Kuwait	5.4	3.8	-1.6
Kenya	7.9	6.4	-1.4
Mexico	4.7	3.3	-1.4
Jamaica	3.8	2.5	-1.3
Thailand	3.6	2.3	-1.3
Honduras	6.4	5.1	-1.3
Ecuador	5.1	3.8	-1.3
Peru	5.0	3.7	-1.3
Jordan	7.1	5.8	-1.3
Morocco	5.7	4.5	-1.2
El Salvador	5.4	4.2	-1.2
Indonesia	4.4	3.2	-1.2
Bolivia	5.8	4.7	-1.1
Brazil	4.0	2.9	-1.1
Viet Nam	5.1	4.0	-1.1
Syria	7.4	6.3	-1.1
Colombia	3.8	2.7	-1.1

Fertility still high
Where fertility rates are the highest in the world

	Average no. of births		
	1980	1991	Diff.
Rwanda	8.5	8.5	0.0
Malawi	7.6	7.6	0.0
Côte d'Ivoire	7.4	7.4	0.0
Uganda	7.0	7.3	+0.3
Yemen	7.7	7.3	-0.4
Angola	6.9	7.2	+0.3
Benin	7.1	7.1	0.0
Mali	7.1	7.1	0.0
Ethiopia	6.8	7.0	+0.2
Somalia	7.0	7.0	0.0
Burundi	6.8	6.8	0.0
Liberia	6.8	6.8	0.0
Oman	7.2	6.8	-0.4
Tanzania	6.8	6.8	0.0
Lao Rep	6.7	6.7	0.0
Zaire	6.6	6.7	+0.1
Togo	6.6	6.6	0.0
Madagascar	6.6	6.6	0.0
Mauritania	6.5	6.5	0.0
Saudi Arabia	7.3	6.5	-0.8

DISPARITY

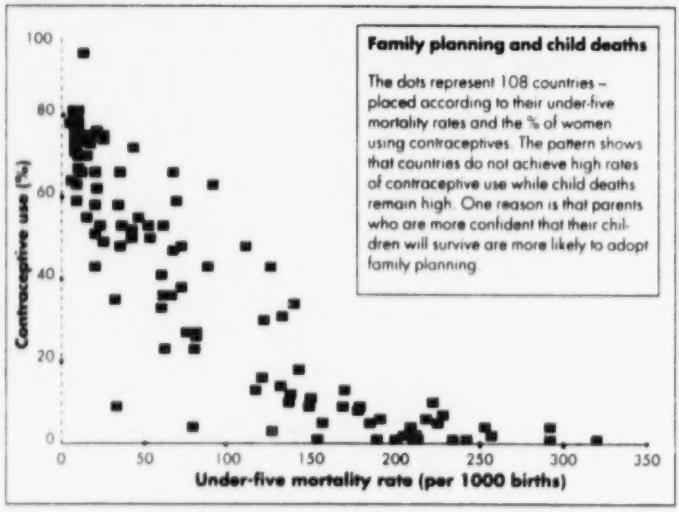
Populations to double in 35 years

On current trends, a total of 61 nations are set to double their populations in one generation between 1990 and 2025. Three quarters of them are in Africa or the Middle East.

Fastest growth

The 20 fastest-growing nations in the world (populations over 1 million)

	Total population (millions) 1990	2025	Multiplication factor
Côte d'Ivoire	12.0	37.9	3.2
Oman	1.5	4.7	3.1
Yemen	11.7	34.2	2.9
Rwanda	7.0	20.6	2.9
Angola	9.2	26.6	2.9
Syria	12.4	35.3	2.9
Tanzania	24.0	69.2	2.9
Libya	4.5	12.9	2.8
Liberia	2.6	7.2	2.8
Madagascar	12.0	33.7	2.8
Zaire	37.4	104.5	2.8
Saudi Arabia	14.9	40.4	2.7
Kenya	23.6	63.8	2.7
Jordan	4.0	10.8	2.7
Somalia	8.7	23.4	2.7
Mali	9.2	24.6	2.7
Benin	4.6	12.4	2.7
Togo	3.5	9.4	2.7
Ethiopia	49.8	130.7	2.6
Uganda	17.6	45.9	2.6


Family planning and child deaths
The dots represent 108 countries – placed according to their under-five mortality rates and the % of women using contraceptives. The pattern shows that countries do not achieve high rates of contraceptive use while child deaths remain high. One reason is that parents who are more confident that their children will survive are more likely to adopt family planning.
Contraceptive use (%)
Under-five mortality rate (per 1000 births)
0
20
40
60
80
100
0
50
100
150
200
250
300
350

Contraceptive use at 50%

In one generation, the proportion of married women in the developing world who are using contraception has risen to an estimated 50%. But one pregnancy in every five in the developing world is unplanned and unwanted.

The table gives the current level of contraceptive use in the ten most populous countries with two thirds of the developing world's people.

The percentage of married women using contraception (1987-1991)

China	72
India	43
Indonesia	48
Brazil	66
Pakistan	12
Bangladesh	31
Nigeria	6
Mexico	53
Viet Nam	53
Philippines	36

Sources: United Nations Population Division and Institute for Resource Development

1 billion less if women could choose

The rate of population growth in the developing world would fall by approximately 30% if women could choose how many children to have. Total developing-world population in the year 2025 would be about 1 billion people fewer than currently projected (see chart).

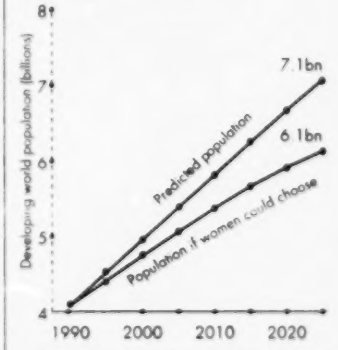
The unmet need for family planning has been revealed by surveys in all parts of the developing world over recent years. In some cases, the desired family size is only about half of the actual family size. The average woman in Peru, for example, wants two children but has four.

In total, an estimated 120 million women in the developing world do not want any more children but are not using any effective means of avoiding another pregnancy.

Family planning can drastically reduce illness, disability, and maternal and child deaths. It could also reduce the toll of unsafe abortion which kills an estimated 100,000 young women every year.

It is now almost 20 years since the first World Population Conference agreed that "all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so".

If women could choose



Sources: Predicted world population growth: United Nations, World Population Prospects 1990; Impact of women's preferences: Brazil household survey in 22 countries, 1986 to 1989, see Charles F. Westoff, "Reproductive preferences: a comparative view", Demographic and Health Surveys Comparative Studies no. 3, Institute for Resource Development, 1991

Some poor countries do better in reducing family size

Some very poor countries have achieved lower fertility rates than some countries with twice the level of economic wealth. The key to their achievement is that many other factors influence fertility – including the education of women, the availability of family planning services, and child survival rates.

6 countries with GNP per capita below $1000, average no. of births below 4

	GNP per capita $	Average no. of births	Under-five mortality rate	Female literacy rate %
China	370	2.3	43	62
Sri Lanka	500	2.5	21	84
Indonesia	610	3.2	111	75
Albania	700	2.8	31	—
Dominican Rep	950	3.5	53	82
Korea, Dem	970	2.4	34	—

6 countries with GNP per capita above $2000, average no. of births above 4

	GNP per capita $	Average no. of births	Under-five mortality rate	Female literacy rate %
Algeria	2020	5.0	61	46
Iran	2320	6.1	62	43
South Africa	2530	4.2	72	75
Botswana	2590	5.2	60	65
Oman	5650	6.8	33	—
Saudi Arabia	7050	6.5	43	48

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PROGRESS FOR WO

A SUMMARY

Despite the lack of statistics, it is clear that the contribution of women to both domestic and economic life is consistently undervalued. One of the consequences is that both the needs and the potential of women are usually neglected in the allocation of resources, investments, credit, training, and technology.

The evidence of recent years shows that this imbalance between the many kinds of contribution women make, and the many kinds of discrimination they suffer, represents not only one of the world's greatest injustices but also one of its greatest inefficiencies.

The greatest injustice

It is now almost twenty years since the World Conference of the International Women's Year called on the United Nations to begin collecting and analysing the statistics that would help to monitor progress for the world's women. In particular, the Conference asked for closer monitoring of women's health and education, of changes in child-bearing patterns and family life, of progress for women in politics and decision making, and of women's contribution to economic life both inside and outside the home.

Some of the results of the closer attention being paid to these issues are set out in the following pages (but see also the chapters on health, education, and family planning). In particular, the tables on the following pages rank the nations of the world according to one of the very few indicators of the well-being of women that is available for all nations – the maternal mortality rate.

The statistical monitoring of progress for women is critical to the cause of equality for women and to the cause of development. Without statistics, one of the greatest injustices and greatest inefficiencies of the modern world runs the risk of being minimized by dependence on anecdotal and partial evidence.

The contribution

First of all, closer study and better statistics have more fully revealed the disproportionate contribution of women to both family and economic life. Many studies, for example, have shown that women work longer hours than men in almost all societies. In Africa and Asia, studies suggest that women work an average of 13 hours a week more than men. In Latin America, the difference is almost six hours, in Japan about two hours, in Western Europe about five to six hours. In Eastern Europe and the countries of the former Soviet Union the difference creeps up to about seven hours.

It was already widely known that women were responsible for fetching most of the poor world's water, collecting most of its fuel, cooking its meals, cleaning its compounds, washing its clothes, shopping for its needs, looking after its old and its ill, and bearing and caring for its children. Only more recently has it become widely known that women are also responsible for growing the great majority of the poor world's food and for storing and marketing most of its crops. On top of all such responsibilities, there has also been a steep rise in the number of women who contribute to, or are responsible for, cash income through employment outside the home.

There is still a long way to go before the contribution of women is fully recognized in the statistics that play such an important part in the making of policy and the allocation of investments and resources. Much of the work done by women in both industrialized and developing countries is still not considered economically productive and still not taken into account in the compilation of national economic statistics.

But it is abundantly clear that the multiple burdens of womanhood are too much and that they are increasing, in most countries, as economic obligation is added to domestic responsibility.

The rewards

Closer monitoring has also shown that in return for this disproportionate contribution women generally receive much less than men in the way of incomes, services, credit, investments, protection, and human rights.

Where women do paid work outside the home, their wages are on average between 30% and 40% less than those of men, and there is no sign of this gap narrowing. In many countries, twice as many boys as girls become literate. In some countries, twice as many boys as girls are brought to health centres for treatment. Employment rights, social security rights, legal rights, property rights, and even civil and political liberties are all likely to depend upon being born male or female.

Over the last decade, in particular, closer attention to the many kinds of contribution women make, and the many kinds of discrimination they suffer, has shown that this imbalance represents not only one of the world's greatest injustices but also one of its greatest inefficiencies.

Discrimination against women in technology, training and credit, for example, withholds the keys of increased productivity from that half of the population. Very often it denies the opportunity for increased productivity to those who need it most and can use it best.

Lost opportunities

Similarly, the neglect of women in the provision of social services is one of the main causes of poverty's perpetuation.

Discrimination against girls in education, for example, leads to an array of lost opportunities for human and economic progress. Over many years and in many countries, the education of women has been shown to be associated with the confidence to adopt new ways, the propensity to make greater use of social services, the ability to earn higher incomes, the improvement of child care and nutrition, the reduction of child deaths, the acceptance of family planning, the reduction of average family size, and the literacy of the succeeding generation. Empowering women with at least basic education and literacy is therefore one of the most important single elements in the development process. But it is also one of the most important steps towards women gaining more control over their own lives, more equality in decision taking in the family and community, and more opportunity to develop their own potential.

Water and sanitation is another obvious example. In many regions, women and girls spend several hours a day collecting water. They also lose days and weeks to coping with the illnesses which are the result of that water not being safe. The cost of bringing clean, piped water to a community can be as little as $2.00 per person per year. The benefits include very significant savings in the time, energy, and productivity of women and in the health and well-being of the community in general.

The right to choose

Finally, lack of investment in family planning services, combined with male dominance of decision making about family size, means that an extraordinary opportunity is being lost to improve the lives of millions of women and at the same time to improve the prospects for sustainable economic development.

It is now clear that hundreds of millions of women in the developing world want the right to determine how many children they will have and when. Pages 31 to 35 summarize the multiple benefits of meeting that demand. It would save lives and improve the health of millions of women; it would improve the health, nutrition, and education of millions of children; and it would give the women of the developing world more control over their own lives.

Finally, the closer statistical monitoring of those aspects of poverty and development that are of most concern to women has begun to reveal the true extent of the tragedy of illegal abortion and maternal mortality – the subject of the league table on the following pages.

An estimated 1,500 women are dying every day of the year from the complications of pregnancy and childbirth. Perhaps 300 women a day are dying as a result of illegal abortions. Millions more sustain injuries and disabilities which are often secret, embarrassing, painful, and lifelong. Even though the facts are becoming known, the suffering and fear remains unimaginable. And its continuance is unconscionable. – *PA*

PROGRESS FOR WO

LEAGUE TABLE OF

These pages list all countries according to their maternal mortality rates – the number of women who die from causes related to pregnancy or giving birth (for every 100,000 births).

In total, maternal mortality claims the lives of an estimated half a million women every year – 99% of them in the developing world.

The maternal mortality rates shown here reflect the strength of health services generally. But progress in reducing maternal deaths also reflects the priority given to a problem that is of crucial concern to most women.

SUB-SAHARAN AFRICA

1	South Africa	83
2	Mauritius	99
3	Zambia	150
4	Benin	160
5	Kenya	170
5	Malawi	170
7	Gabon	190
8	Rwanda	210
9	Botswana	250
10	Mozambique	300
10	Uganda	300
12	Tanzania	340
13	Namibia	370
14	Togo	420
15	Cameroon	430
16	Sierra Leone	450
17	Madagascar	570
▶	*Regional average*	*590*
18	Central African Rep.	600
18	Senegal	600
20	Guinea-Bissau	700
20	Niger	700
22	Guinea	800
22	Nigeria	800
22	Zaire	800
25	Burkina Faso	810
26	Congo	900
27	Chad	960
28	Ghana	1000
29	Somalia	1100
30	Mali	2000
	Angola	NO DATA
	Burundi	NO DATA
	Côte d'Ivoire	NO DATA
	Ethiopia	NO DATA
	Lesotho	NO DATA
	Liberia	NO DATA
	Mauritania	NO DATA
	Zimbabwe	NO DATA

MIDDLE EAST and NORTH AFRICA

1	Kuwait	6
2	Saudi Arabia	41
3	Jordan	48
4	Tunisia	50
5	Libya	80
6	Iran	120
6	Iraq	120
8	Algeria	140
8	Syria	140
10	Turkey	150
▶	*Regional average*	*210*
11	Egypt	270
12	Sudan	550
	Lebanon	NO DATA
	Morocco	NO DATA
	Oman	NO DATA
	U. Arab Emirates	NO DATA
	Yemen	NO DATA

SOUTH ASIA

1	Sri Lanka	80
2	India	460
▶	*Regional average*	*490*
3	Pakistan	500
4	Bangladesh	600
5	Afghanistan	640
6	Nepal	830
7	Bhutan	1310

WORLD AVERAGE

Deaths per 100,000 births

Maternal mortality

Few developing countries maintain up-to-date statistics of maternal mortality rates (deaths of women related to pregnancy and childbirth per 100,000 births). The figures presented here are derived from *Maternal mortality: a global factbook* (World Health Organization, 1991). They are the latest available estimates, but are drawn mostly from the 1980s.

Unlike statistics for under-five deaths or total fertility, estimates of maternal mortality are not usually based on national surveys. They are drawn up by piecing together evidence from community studies and hospital records.

Surveys require a large sample size (as maternal mortality is a less common occurrence than child death) and must also attempt to discover the cause of death. This process may be made more difficult by social, religious, emotional, or practical considerations, especially if the woman concerned was unmarried or if death was the result of illegal abortion. Maternal mortality is therefore generally underestimated.

MATERNAL DEATHS

EAST ASIA and PACIFIC

1	Hong Kong	6
2	Singapore	10
3	Korea, Rep.	26
4	Korea, Dem.	41
5	Thailand	50
6	Malaysia	59
7	China	95
8	Philippines	100
9	Viet Nam	120
10	Mongolia	140
▶	*Regional average*	*160*
11	Lao Rep.	300
12	Indonesia	450
13	Myanmar	460
14	Cambodia	500
15	Papua New Guinea	900

CENTRAL AMERICA and CARIBBEAN

1	Costa Rica	36
2	Cuba	39
3	Panama	60
4	Mexico	110
4	Trinidad and Tobago	110
6	Jamaica	120
▶	*Regional average*	*160*
7	Guatemala	200
8	Honduras	220
9	Haiti	340
	Dominican Rep.	NO DATA
	El Salvador	NO DATA
	Nicaragua	NO DATA

SOUTH AMERICA

1	Uruguay	36
2	Chile	67
3	Argentina	140
4	Ecuador	170
5	Brazil	200
5	Colombia	200
▶	*Regional average*	*210*
7	Paraguay	300
7	Peru	300
9	Bolivia	600
	Venezuela	NO DATA

INDUSTRIALIZED COUNTRIES

1	Ireland	2
2	Australia	3
2	Belgium	3
2	Denmark	3
2	Israel	3
2	Norway	3
7	Italy	4
8	Canada	5
8	Germany	5
8	Greece	5
8	Spain	5
8	Sweden	5
8	Switzerland	5
14	Austria	8
14	USA	8
14	United Kingdom	8
17	Bulgaria	9
17	France	9
19	Czechoslovakia (former)	10
19	Netherlands	10
19	Portugal	10
22	Finland	11
22	Japan	11
22	Poland	11
25	New Zealand	13
▶	*Group average*	*13*
26	Hungary	15
27	Romania	150
	Albania	NO DATA

Emergency care needed

A woman born in Africa today has a 1 in 20 chance of dying in childbirth. The risk for a woman born in Europe or North America is about 1 in 3600 (see chart).

The main opportunity for reducing maternal deaths is the prevention of unwanted pregnancies and unsafe abortions. Once childbirth has begun, reducing the risks depends heavily on the availability of emergency obstetric care. Even improvements in the general health and nutrition of women have relatively little effect. In the United Kingdom and the United States, maternal mortality remained at very high levels even after rising living standards had helped reduce infant mortality to very low levels. Only in the 1930s, when emergency obstetric care became widely available, did maternal mortality begin its steep fall. In certain communities in the United States, where modern medical services are refused on religious grounds, maternal mortality rates are still 100 times higher than the US average.

The birth gamble

Risks of maternal death (over a lifetime) by region

	Lifetime risk
Sub-Saharan Africa	1 in 20
South Asia	1 in 40
M East and N Africa	1 in 80
South America	1 in 130
C America and Caribbean	1 in 150
E Asia and Pacific	1 in 200
Industrialized countries	1 in 3600

TARGET

A halving of the 1990 maternal mortality rates.

All women to have prenatal care, trained birth attendants, and referral facilities for obstetric emergencies.

FOR THE YEAR 2000

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PROGRESS FOR WO

ACHIEVEMENT AND

In most nations, women are beginning to make progress towards greater equality in education, in legal status, in the right to choose when to have children, and in opportunities outside the home.

But it is still common for women to work twice as many hours a day as men.

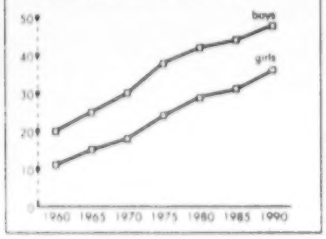
In developing countries, women grow most of the food and contribute increasingly to cash incomes.

But they are still expected to fetch wood and water, clean and cook, wash and shop, look after the old and the ill, and bear and care for children.

Sri Lankan girls – poor but literate

Secondary consideration

% girls and boys in secondary school, developing world, 1960 - 1990



12 of poorest reach 60% literacy for women

Some of the poorest countries in the world have outstanding records in promoting literacy for women.

Twelve countries with per capita GNPs of less than $1000 have female literacy rates of 60% or better. Four of them – Sri Lanka, Viet Nam, the Dominican Republic, and the Philippines – have surpassed the 80% mark.

Sri Lanka's female literacy rate of 84% stands more than twice as high as the average for South Asia.

Ten countries at significantly higher levels of economic development still fall short of the 60% mark for female literacy.

All literacy statistics should be regarded as approximate, as there is no hard and fast definition of exactly what is meant by being able to read and write.

Poor but literate

GNP per capita below $1000, female literacy 60% plus

	% women literate 1990	GNP per capita 1991($)
Philippines	90	740
Viet Nam	84	240
Sri Lanka	84	500
Dominican Rep.	82	950
Indonesia	75	610
Madagascar	73	210
Myanmar	72	220
Zimbabwe	72	620
Honduras	71	570
Bolivia	71	650
Zambia	65	420
China	62	370

Lagging

GNP per capita above $1000, female literacy below 60%

	% women literate 1990	GNP per capita 1991($)
Morocco	38	1030
Iran	43	2320
Congo	44	1120
Algeria	46	2020
Saudi Arabia	48	7050
Gabon	49	3780
Iraq	49	1500
Libya	50	5330
Syria	51	1110
Tunisia	56	1510

10 reach 90%

Ten developing countries have achieved literacy rates for women of 90% +.

	% women literate
Jamaica	99
Uruguay	96
Argentina	95
Korea, Rep.	94
Cuba	93
Costa Rica	93
Chile	93
Venezuela	90
Thailand	90
Philippines	90

Sources: Unesco, UN ECE, Commission on Status of Women, 1991; UNDP, World Bank, World Development Report, 1991

Maternal deaths not just a question of national wealth

The league tables on the previous page show that in no other area of life is the gap between countries as wide as it is in the frequency of maternal death. The number of women who die per 100,000 births ranges from 2 or 3 in Australia, Israel, and Northern Europe to between 1000 and 2000 in some parts of the developing world. But the gap is not only a gap between rich and poor. The overall status of women, and especially their ability to control how many children to have and when, can be even more important than a country's economic standing. No country has succeeded in reducing maternal mortality to low levels without providing emergency obstetric care to cope with complications in childbirth.

Listed below are seven very poor countries with low maternal death rates – and seven richer countries with significantly higher maternal mortality.

7 poor doing well

GNP per capita $500 or less, maternal mortality below 200

	Per capita GNP($)	Maternal mortality
Sri Lanka	500	80
Zambia	420	150
Benin	380	160
China	370	95
Kenya	340	170
Viet Nam	240	120
Malawi	230	170

7 richer not doing so well

GNP per capita above $1000, maternal mortality 200 or more

	Per capita GNP($)	Maternal mortality
Brazil	2920	200
Botswana	2590	250
Colombia	1280	200
Paraguay	1210	300
Congo	1120	900
Namibia	1120	370
Peru	1020	300

Sources: GNP, World Bank, World Development Report, 1991; Maternal mortality, Unicef, State of the World's Children, 1991

DISPARITY

Where homes are headed by women

A quarter or more of households are headed by women in 24 out of 78 countries for which figures are available. In the great majority of cases, this means that the household is made up of a woman and children – and no man. In some cases, men are absent because they have migrated in search of work. The proportion of households headed by women has risen in all regions in recent years.

Botswana – nearly half of all households headed by women

Heading home
% of households headed by women (1980s)

Saint Kitts and Nevis	46	Cuba	28
Grenada	45	Poland	27
Botswana	45	Sweden	27
Barbados	44	Ghana	27
Saint Vincent and Grenadines	42	Rwanda	25
Saint Lucia	39	Australia	25
Dominica	38	Canada	25
Norway	38	Puerto Rico	25
Jamaica	34	Switzerland	25
Austria	31	Trinidad and Tobago	25
USA	31	United Kingdom	25
Malawi	29		
Zambia	28		

SOURCE United Nations, *The world's women 1970–1990: trends and statistics* 1991

Where women are fewer than men

Girl children have a better survival rate than boys and women normally live longer than men. Even with the natural compensation of more male than female births, this still means that most nations have more women than men. In the industrialized world, for example, the ratio is 106 women for every 100 men.

But in some developing countries, there are many fewer women than men. The reason may be a lower survival rate for girls – either because they receive less health care or because of the female infanticide which, whether by neglect or intention, still occurs in some countries. High maternal mortality rates may also be a cause, as an estimated half a million women die each year from the complications of pregnancy and giving birth. Unsafe abortion also takes its toll, killing approximately 100,000. Other possible causes include widow burning and dowry deaths.

The table shows the nine developing countries which have 95 or fewer women for every 100 men; this means that there are 10% fewer women than could be expected.

Disappearing women
Women per 100 men (1990)

Pakistan	92
Papua New Guinea	93
India	94
Hong Kong	94
Bangladesh	94
Albania	94
China	94
Afghanistan	95
Nepal	95

SOURCE United Nations Statistical Office and Population Division, unpublished data. This list excludes countries which have large numbers of male immigrants.

South Asia – 10% of women missing

Where parliament is still 95% male
% women MPs (1991)

Pakistan	1
Kenya	1
Turkey	1
Korea, Rep	2
Mongolia	2
Egypt	2
Japan	2
Algeria	2
Malta	3
Afghanistan	3
Yemen	3
Nepal	3
Albania	4
Romania	4
Barbados	4
Thailand	4
Central African Rep	4
Togo	4
Bahamas	4
Tunisia	4
Maldives	4
Argentina	5
Côte d'Ivoire	5
Sri Lanka	5
Zaire	5

Women in politics

Although women have the vote in all democracies, no country in the world has as many women members of parliament as men. In only four countries does the proportion of women MPs rise above one third of the total – Finland, Norway and Sweden, plus Guyana which leads the developing world in the proportion of politicians who are female.

Regionally, Asia and Europe lead the way with about 13% female participation in national parliaments (all figures are for 1991, the latest available year).

In the world as a whole, only about one parliamentary seat in nine is occupied by a woman. This represents a slight fall from the level of 13% recorded in 1989.

In democratic systems, the proportion of nationally elected officials who are women is a good barometer of progress towards realizing the principle of equality.

Where there are most women MPs
% of women MPs (1991)

Asia	13
Europe	13
Americas	12
Sub-Saharan Africa	9
Pacific	6
Arab States	4
World average	11

Where there are no women MPs

Belize	Morocco
Bhutan	Papua New Guinea
Comoros	Saint Lucia
Djibouti	Solomon Islands
Jordan	Tonga
Kiribati	U Arab Emirates
Lebanon	

Where women are going backwards
There are 15 countries in which the proportion of women elected to national office has fallen since the mid–1970s:

% of women MPs

	1975	1991	% pt. fall
Albania	33	4	-29
Hungary	29	7	-22
Mongolia	23	2	-21
Bulgaria	19	9	-10
Zaire	11	5	-6
Barbados	8	4	-4
Côte d'Ivoire	9	5	-4
Argentina	9	5	-4
Korea, Rep	6	2	-4
Pakistan	4	1	-3
Kenya	4	1	-3
Poland	16	14	-2
China	23	21	-2
Korea, Dem	21	20	-1
Malta	4	3	-1

SOURCE Inter-Parliamentary Union, *Distribution of seats between men and women in national parliaments*, Reports and documents, no 18, 1991

45

THE INDUSTRIALI

A SUMMARY

Recent decades have brought rapid improvements for the children of the industrialized nations. But progress has now slowed and, in some countries, been thrown into reverse.

Poverty still afflicts between 5% and 20% of children even as new problems emerge.

In most countries, there has been a steep rise in divorce, single-parent families, and the numbers of women who work outside the home. There has been no compensating increase in the time fathers spend with children. Millions of the industrialized world's children are now facing a famine of parental time.

The pressures that devalue children

The industrialized nations were asked to respond to the 1990 World Summit for Children in two different ways. First, they were asked to give more priority to meeting the needs of children in their own societies. Second, they were asked to give more priority to the kind of overseas aid which would help improve the survival, health, nutrition, and education of children in the developing world.

The following pages provide a glimpse of how the industrialized nations currently measure up to these two different tests. The facts and figures on page 44 tell their own story of the industrialized world's aid programmes. This introduction therefore focuses on children in the industrialized nations.

Looking after its own

Whether measured by health, physical growth rates, disability reduction, or educational level, the quarter century from 1950 to 1975 saw remarkable progress for children in all industrialized nations. But particularly in the Anglo-American world, there are signs that this rapid progress has been brought to a halt and may now be going into reverse.

In almost all industrialized nations, for example, a significant fraction of children are still living in a poverty so severe that their basic needs for adequate nutrition, basic health care, and primary education are not reliably met. In the richest country of all, that proportion has been increasing: 15% of children in the United States lived below the poverty line in 1970; today the proportion is 20%.

The main causes of continued child poverty are rising unemployment and falling wage levels for unskilled workers, rising divorce rates and the increase in single-parent families, the failure of government taxation policies and social services to mitigate poverty, and the steep rise in the cost of housing in some industrialized countries.

Starved of time

One consequence of these economic and social changes is that millions of children are also increasingly being deprived of parental time and attention.

In almost every industrial country, the proportion of mothers who work outside the home has been increasing steeply. For a minority of women, this is a response to new opportunities for interesting and rewarding careers; but in the vast majority of cases, mothers are taking unskilled jobs with low status and low pay. Divorce or abandonment play their part, but more often it is a case of one income in the family no longer being enough. In the United States, the proportion of women who work outside the home has jumped from 30% in 1960 to 66% in 1988 partly to compensate for a 20% fall in male wages over roughly the same period. In Australia, the number of women going out to work rose by 40% in the 1980s as the average wage fell by about $30 a week. In the United Kingdom, where house prices have tripled in real terms since 1970, mortgage repayments now claim about 40% of average family income and most households need two wage-earners.

By and large, there has been no compensating increase in the time given to children by their fathers. Indeed—in some places men are working longer hours, often because of the need to hold onto jobs in an increasingly competitive economic climate. The average working week in the United States, for example, has lengthened by the equivalent of a full working day (from just over 40 hours to about 47 hours) between the beginning of the 1970s and the end of the 1980s. According to *The Wall Street Journal*, almost 90% of senior executives work at least a 10-hour day, and most are working a longer week and taking shorter holidays than they were ten years ago. Similar trends are evident in the United Kingdom, where executives work a 55-hour week and half do not take up their full holiday entitlement.

The inevitable result is that millions of parents are spending significantly less time with their children. According to some estimates, American children spend an average of 10 to 12 hours a week less with their parents than they did in 1960. More difficult to quantify is the effect on the time that parents and children do spend together. But if both parents arrive home tired or stressed, then it is obvious that there will be little time or energy left to build the kind of relationships which help children to grow up with confidence and self-esteem, discipline and respect, and the ability to be happy and to contribute to the happiness of others.

Abandoning children

Partly as a result of such pressures, the single-parent family is on the rise in most industrialized nations. The proportion of American children growing up without the presence of a father has increased from just over 10% in 1960 to over 25% by the end of the 1980s. In the United Kingdom, the rise has been even steeper: a quarter of all babies born in Britain in 1990 were born to single mothers.

The chart on page 45 shows how different industrialized countries have acted to mitigate the effect of economic forces on children. In France, Germany, the Netherlands, and Sweden, tax policies and child benefit schemes have reduced child poverty to 5% or less. In Canada, Australia, and the United Kingdom, poverty mitigation has brought the figure down to less than 10%. Only in the United States does government policy have no really significant effect on the 20% or more of children living below the national poverty line. To some extent, this policy of neglect seems to have applied only to children. In both the United States and Canada, poverty has decreased among the elderly and risen among the young.

Signs of stress

Some industrialized countries are clearly offering their children greater protection against these trends. In general, Japan and the countries of southern Europe appear to be suffering less erosion of family and community support for the child and for the job of being a parent. In much of Europe, the working week has been slowly shrinking and the package of rights and benefits available to parents when a child is born has improved. In the United States, by contrast, about 60% of working women have no benefits or job safeguards when they give birth.

Nonetheless, the consequences of increasing pressures on family life are beginning to show up in some disturbing statistics for almost all the industrialized countries. Many nations are witnessing a steady rise in school drop-out rates and underperformance, in reported cases of the physical and sexual abuse of children, in teenage violence and suicide (see page 45), in eating disorders, alcoholism, crime, and drug abuse, and in harder-to-quantify disaffection, demoralization, and disillusionment. These symptoms, increasingly breaking the surface of homes and communities which are not financially poor, tell of the stress on family life and family relationships.

The pattern and the extent of the process differs from country to country but the common strand is that the job of parenting is being devalued, and with it the quality of children's lives and society's future. – *PA*

Many of the facts in this introduction are taken from Child neglect in rich nations, *Sylvia Hewlett, UNICEF, 1991.*

The 1990 World Summit for Children called on the industrialized nations to look again at the progress being made by their own children. In wealthy countries, the problems of poverty linger on and the problems of affluence are on the increase.

The Summit also asked all industrialized nations to re-examine aid budgets to see if they could better serve the year 2000 goals for improving the health, nutrition, and education of children in the developing world.

The aid-ranking tables on this page show how small a part of aid is currently devoted to this cause.

Nordic countries head aid leagues

The industrialized world gives about one third of 1% of its GNP in overseas aid – about $75 a year from each citizen. An aid target of 0.7% of donor country GNP was agreed on in the 1960s.

Norway, Denmark and Sweden occupy the first three places in the aid leagues – whether measured by percentage of GNP or aid given per head.

Aid as % of GNP (1991)

Norway	1.1
Denmark	1.0
Sweden	1.0
Netherlands	0.9
Finland	0.8
France	0.5
Canada	0.5
Belgium	0.4
Germany	0.4
Australia	0.4
Switzerland	0.4
Austria	0.3
United Kingdom	0.3
Japan	0.3
Portugal	0.3
Italy	0.3
New Zealand	0.3
Spain	0.2
USA	0.2
Ireland	0.2

Aid given per head ($)

Norway	282
Sweden	234
Denmark	231
Finland	180
Netherlands	168
France	130
Switzerland	118
United Kingdom	99
Germany	92
Canada	92
Belgium	86
Japan	77
Austria	60
Australia	58
Italy	58
USA	44
Ireland	37
New Zealand	29
Spain	27
Portugal	16

Aid to meet the needs of the poorest

Less than 10% of aid is spent on basics

Less than 10% of aid is allocated directly to meeting the most obvious needs of the poorest people – primary health care, primary education, clean water, safe sanitation, and family planning.

The funding of such programmes is not the only way to meet basic needs. Aid that creates jobs and incomes allows people to meet their own and their families' needs by their own efforts.

Nonetheless, there is a clear case for restructuring aid programmes so that at least 20% of the total goes directly to basics. Low-cost solutions are available for many of the major problems facing the children of the developing world; aid could help ensure that the resources are available to put those solutions into effect on the required scale.

Many countries devote the bulk of educational aid to universities or advanced studies for relatively few individuals rather than to the improvement of primary education for the majority of children.

Similarly, aid for health is often directed towards hospitals and high-cost medical equipment serving the needs of an urban minority rather than primary health care for the poor majority.

Aid to basic education

Aid to basic education as % of all direct aid to education (1990)

Sweden	54
USA	43
Switzerland	23
Japan	22
Netherlands	16
Denmark	14
Finland	12
Canada	5
United Kingdom	4

Aid to family planning

% of aid given to population programmes (1990)*

Norway	4.2
Finland	2.5
USA	2.5
Sweden	2.1
Denmark	1.8
Canada	1.7
United Kingdom	1.4
Netherlands	1.3
Switzerland	0.9
Germany	0.8
Japan	0.7
New Zealand	0.5
Australia	0.4
Belgium	0.3
Italy	0.1
Austria	0.1
France	0.1
Average	1.2

US child poverty twice European level

With 20% of its children living below the national poverty line, the United States has more than double the child poverty rate of any other industrialized country.

Canada, Australia, and the United Kingdom form a second group with about 10% of children below national poverty lines (family income below 40% of median disposable income). Sweden, France, the Netherlands, and former West Germany have all succeeded in reducing child poverty levels to less than 5%.

The poor performances of the United States, the United Kingdom, Canada and Australia reflect setbacks for the poor during the 1980s. The proportion of families living below the poverty line doubled in the UK and rose 40% in the US between 1979 and 1986.

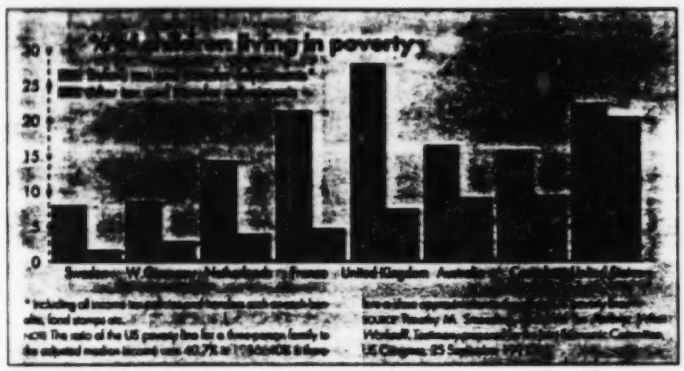
The fact that child poverty rates are twice as high in the US is caused largely by the failure of tax and transfer policies to mitigate poverty to the same degree as in other industrialized countries (see chart).

The United States also leads the rankings for murders of young people. Nine out of ten killings of young people in the industrialized world happen in the US.

Australia, Norway, Canada and Switzerland head the league for the suicide of young people. Among those aged 15 to 24, suicide has risen in 11 out of 14 industrialized countries over the last 20 years – more than doubling in Spain and Norway.

Only Sweden, Japan, and former West Germany have brought about a fall in teen suicide.

Canada and the United States lead the world in the proportion of young adults enrolled in higher education. Two thirds of Canadians aged 20 to 24 are still studying, just ahead of the 63% scored by the USA. Only Italy, Ireland, Switzerland and the United Kingdom have less than 30% of their young adults still in education.



Murder
Annual deaths by homicide per 100,000 aged 15-24

	Number	Rate per 100,000
USA	5718	15.3
Canada	121	3.1
Italy	179	1.9
Norway	9	1.4
Spain	93	1.4
Switzerland	12	1.3
Sweden	13	1.1
Denmark	8	1.0
Netherlands	21	0.9
UK	80	0.9
France	59	0.7
Japan	73	0.4

Suicide
Annual deaths by suicide per 100,000 aged 15-24

	Rate per 100,000 1970	1987-1990
Australia	8.6	16.4
Norway	6.2	16.3
Canada	10.2	15.8
Switzerland	13.7	15.7
USA	8.0	13.2
Sweden	13.3	12.2
France	7.0	10.3
W Germany	13.4	9.6
Denmark	9.0	9.2
UK	4.3	7.2
Japan	13.0	7.0
Netherlands	4.9	6.7
Spain	1.7	4.3
Italy	2.9	3.2

Progress of 70s stalled in 80s

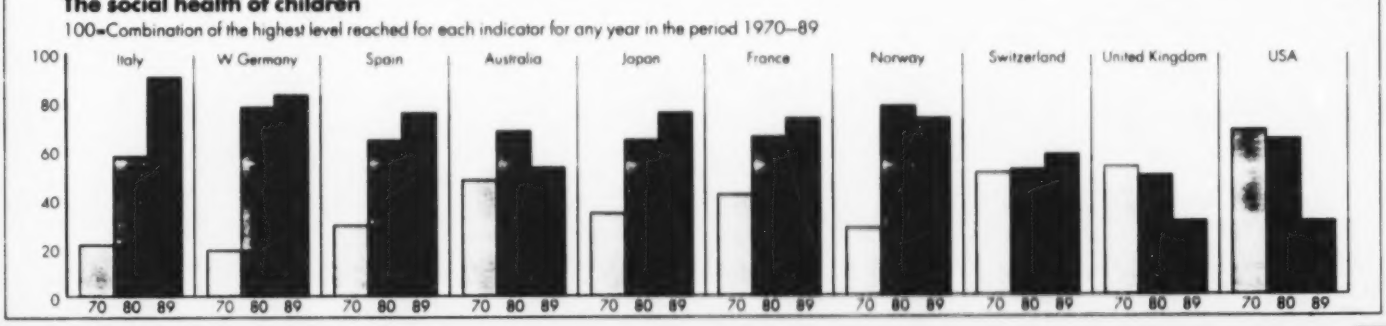
A new report on children in ten industrialized countries shows that steady progress has been made over the last 20 years except in the United States and the United Kingdom, where children are judged worse off today than they were in 1970.

The report, prepared by Fordham University's Institute for Innovation in Social Policy, shows that progress in most of the countries studied was rapid in the 1970s but stalled in the 1980s. The best performing countries were Italy and West Germany, with Norway and Spain also showing strong progress.

Lack of standardized statistics meant that only four measures could be used – infant mortality, government spending on education, teenage suicide, and income distribution.

For each indicator, a nation's own best performance since 1970 is given a value of 100. Performance in any one year is then recorded as a percentage of this maximum score. The indicator scores are then averaged.

The charts show the results. They cannot be used for inter-country comparisons as they are based not on a fixed standard but each country's own best performance in the past.



CHILD RIGHTS

THE CONVENTION

The Convention on the Rights of the Child seeks to protect children everywhere against exploitation, neglect and abuse.

Many of its provisions are reflected in the year 2000 goals for improving health, nutrition and education.

Monitoring progress towards those goals is therefore one way of monitoring the progress of the Convention.

The tables on these pages show, for each country, whether the Convention on the Rights of the Child has been signed and ratified, and whether a National Programme of Action (NPA) for reaching the year 2000 goals has been drawn up.

SUB-SAHARAN AFRICA

Angola	■ ▲
Benin	■ ▲ ●
Botswana	
Burkina Faso	■ ▲ ●
Burundi	■ ▲ ●
Cameroon	■ ▲
Central African Rep.	■ ▲ ●
Chad	■ ▲ ●
Congo	●
Côte d'Ivoire	■ ▲ ●
Ethiopia	■ ▲
Gabon	■
Ghana	■ ▲ ●
Guinea	■ ▲ ●
Guinea-Bissau	■ ▲
Kenya	■ ▲ ●
Lesotho	■ ▲
Liberia	■ ▲
Madagascar	■ ▲
Malawi	■ ▲ ●
Mali	■ ▲ ●
Mauritania	■ ▲ ●
Mauritius	■ ▲ ●
Mozambique	■ ●
Namibia	■ ▲ ●
Niger	■ ▲ ●
Nigeria	■ ▲ ●
Rwanda	■ ▲ ●
Senegal	■ ▲ ●
Sierra Leone	■ ▲ ●
Somalia	
South Africa	■
Tanzania	■ ▲ ●
Togo	■ ▲
Uganda	■ ▲ ●
Zaire	■ ▲
Zambia	■ ▲
Zimbabwe	■ ▲ ●

MIDDLE EAST and NORTH AFRICA

Algeria	■ ▲ ●
Egypt	■ ▲ ●
Iran	■ ●
Iraq	
Jordan	■ ▲
Kuwait	■ ▲ ●
Lebanon	■ ▲
Libya	■ ▲
Morocco	■ ▲ ●
Oman	
Saudi Arabia	
Sudan	■ ▲ ●
Syria	■ ●
Tunisia	■ ▲ ●
Turkey	■
United Arab Emirates	
Yemen	■ ▲

SOUTH ASIA

Afghanistan	■
Bangladesh	■ ▲ ●
Bhutan	■ ▲ ●
India	■ ▲ ●
Nepal	■ ▲ ●
Pakistan	■ ▲ ●
Sri Lanka	■ ▲ ●

■ Country has signed the Convention on the Rights of the Child.

▲ Country has ratified the Convention on the Rights of the Child.

● Country has finalized National Programme of Action for reaching year 2000 goals.

A promise to keep

The Convention on the Rights of the Child was adopted by the General Assembly of the United Nations on 20 November 1989. Human rights conventions usually take several decades to achieve widespread international acceptance. In only four years, the Convention on the Rights of the Child has been signed or ratified by the great majority of the world's nations.

Signing the Convention indicates a government's intention to ratify. Ratification means that its provisions become binding and that governments undertake to submit a report, within two years, of action taken towards compliance. To date, (July 1993), 57 reports have been submitted to the ten-member international Committee on the Rights of the Child.

In many nations, the process of translating the Convention into national law has now begun. In all nations, ratification gives the public, the media, and the non-governmental organizations an agreed platform from which to remind political leaders of their commitments.

ND THE GOALS

EAST ASIA and PACIFIC

Cambodia	■	▲	
China	■	▲	●
Indonesia	■	▲	●
Korea, Dem.	■	▲	
Korea, Rep.	■	▲	●
Lao Rep.	■	▲	
Malaysia			
Mongolia	■	▲	
Myanmar	■	▲	
Papua New Guinea	■	▲	
Philippines	■	▲	●
Singapore			●
Thailand	■	▲	
Viet Nam	■	▲	●

CENTRAL AMERICA and CARIBBEAN

Costa Rica	■	▲	●
Cuba	■	▲	●
Dominican Rep.	■	▲	●
El Salvador	■	▲	●
Guatemala	■	▲	●
Haiti	■		
Honduras	■	▲	●
Jamaica	■	▲	
Mexico	■	▲	●
Nicaragua	■	▲	●
Panama	■	▲	●
Trinidad and Tobago	■	▲	●

SOUTH AMERICA

Argentina	■	▲	●
Bolivia	■	▲	●
Brazil	■	▲	
Chile	■	▲	●
Colombia	■	▲	●
Ecuador	■	▲	●
Paraguay	■	▲	●
Peru	■	▲	●
Uruguay	■	▲	●
Venezuela	■	▲	●

INDUSTRIALIZED COUNTRIES

Albania	■	▲	
Australia	■	▲	
Austria	■	▲	
Belgium	■	▲	●
Bulgaria	■	▲	
Canada	■	▲	●
Denmark	■	▲	●
Finland	■	▲	●
France	■	▲	
Germany	■	▲	●
Greece	■	▲	
Hungary	■	▲	
Ireland	■	▲	
Israel	■	▲	
Italy	■	▲	
Japan	■		●
Netherlands	■		●
New Zealand	■	▲	
Norway	■	▲	●
Poland	■	▲	
Portugal	■	▲	●
Romania	■	▲	
Spain	■	▲	
Sweden	■	▲	●
Switzerland	■		
United Kingdom	■	▲	●
USA			●

NEWLY INDEPENDENT COUNTRIES

National Programmes of Action (NPAs) are not known for these countries since independence has been too recent for them to have drawn up and begun to implement one.

Armenia	■	▲		Lithuania	■	▲
Azerbaijan	■	▲		Macedonia		
Belarus	■	▲		Moldova	■	▲
Bosnia and Herzegovina				Russian Federation	■	▲
Croatia	■	▲		Slovakia	■	▲
Czech Republic	■	▲		Slovenia	■	▲
Estonia	■	▲		Tajikistan		
Georgia				Turkmenistan		
Kazakhstan				Ukraine	■	▲
Kyrgyzstan				Uzbekistan		
Latvia	■	▲		Yugoslavia	■	▲

NOTE Additional signatories to the Convention include the Holy See, Liechtenstein, Monaco and San Marino. San Marino and the Holy See have both ratified the Convention and the Holy See has drawn up an action plan for children.

SOCIAL INDICATORS

LESS POPULOUS COUNTRIES

The main indicators used to construct the league tables in *The Progress of Nations* are the under-five mortality rate, the percentage of children malnourished, the percentage of children reaching grade 5 of primary school, the percentage of children immunized against measles, the maternal mortality rate, and the total fertility rate. Using these same indicators, the following table shows the record of the world's less populous countries (population less than 1 million people). The relative standing of less populous countries can be assessed by comparing the figures given here with the relevant league tables.

The last columns indicate whether the Convention on the Rights of the Child has been signed and ratified, and whether a National Programme of Action (NPA) has been drawn up for the achievement of the year 2000 goals (see pages 46 and 47).

	GNP per capita ($) 1991	Under-5 mortality rate 1991	% under-5 children underweight 1976-1990	% 1-year-old children immunized against measles 1991	% of children reaching grade 5 1980-1990	Maternal mortality rate 1980-1990	Total fertility rate 1991	Convention on the Rights of the Child Signed	Convention on the Rights of the Child Ratified	Year 2000 goals NPA
Antigua and Barbuda	4770	23	10	89	—	—	1.9	✓		
Bahamas	11720	30	—	87	92	69	2.1	✓	✓	
Bahrain	6910	18	—	85	95	34	3.8	✓	✓	✓
Barbados	6630	12	5	87	92	27	1.7	✓	✓	✓
Belize	2050	29	—	74	47	19	4.6	✓	✓	✓
British Virgin Islands	8500	33	—	84	—	—	—			
Brunei Darussalam	20760	10	—	99	83	—	3.2			
Cape Verde	750	61	19	76	68	107	4.4	✓	✓	
Comoros	500	133	—	87	31	500	7.1	✓	✓	✓
Cook Islands	1550	17	—	67	—	—	—			
Cyprus	8640	11	—	74	82	—	2.3	✓	✓	
Djibouti	1210	161	23	79	39	740	6.6	✓	✓	✓
Dominica	2440	20	4	98	91	58	2.7	✓	✓	
Equatorial Guinea	330	202	—	79	—	430	5.9	✓	✓	
Fiji	1830	30	—	84	74	90	3.0	✓		✓
Gambia	360	234	—	87	47	1500	6.2	✓	✓	✓
Grenada	2180	37	—	96	100	103	3.0	✓	✓	
Guyana	290	69	22	76	91	200	2.6	✓	✓	
Iceland	22580	7	—	99	—	0	2.2	✓	✓	
Kiribati	750	85	—	63	98	—	4.1			
Luxembourg	31080	9	—	80	91	0	1.6	✓		
Maldives	460	81	—	97	—	400	6.3	✓	✓	✓
Malta	6850	14	—	80	100	0	2.1	✓	✓	
Marshall Islands	*	28	—	25	—	—	—	✓		✓
Micronesia, Fed. States	*	—	—	89	—	—	4.5	✓	✓	
Montserrat	3330	35	—	99	—	—	2.5			
Palau	790	28	—	98	—	—	—			
Qatar	15860	35	—	79	59	9	4.5	✓		
Saint Kitts and Nevis	3960	43	—	99	—	150	2.6	✓	✓	
Saint Lucia	2500	22	14	82	95	26	3.1	✓	✓	
Saint Vincent and the Grenadines	1730	26	—	99	—	13	2.5			
Samoa	930	59	—	87	—	400	4.6	✓		
Sao Tome and Principe	350	89	17	68	88	79	5.0	✓	✓	
Seychelles	5110	21	6	89	100	60	2.8	✓	✓	
Solomon Islands	560	34	—	74	69	10	5.5			
Suriname	3610	37	—	84	99	89	2.8	✓	✓	
Swaziland	1060	113	10	80	79	110	5.0	✓		✓
Tonga	1100	26	—	86	93	37	3.9			
Turks and Caicos Islands	780	31	—	99	—	—	—			
Tuvalu	650	43	—	79	—	460	—			
Vanuatu	1120	89	20	66	—	107	5.6	✓	✓	

* Range $1500 - $3499

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NATIONAL PERFORMANCE GAPS

The following tables provide additional information on the progress of nations.

Pages 50 and 51 show the national performance gaps, for all countries, in the fields of child survival, nutrition, and primary education. The national performance gap is the difference between the actual level of progress achieved and the expected level of progress for each country's per capita GNP (see pages 10 and 11).

Using the key indicator of the under-five mortality rate, pages 52 and 53 show the average annual rate of reduction achieved in the 1980s and compare this with the rate required in the 1990s if the internationally agreed goal for the year 2000 is to be met. Countries are listed, by region, in order of their likelihood of reaching the goal.

The tables on these pages show each country's national performance gap in the areas of child survival, nutrition, and education.

The national performance gap is the difference between a country's actual level of progress and the expected level for its per capita GNP.

For each indicator, the expected level of achievement has been calculated from the per capita GNPs and the relevant social indicators of all countries (see opposite). The expected level therefore represents the level that the average-performing country could be expected to have reached for its level of GNP per capita.

SOCIAL INDICATO

NATIONAL PERFOR

	GNP per capita	Under-five mortality rate 1991			% of children reaching grade 5			% of under-five children underweight		
		Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
SUB-SAHARAN AFRICA										
Angola	610	—	—	—	34	60	-26	—	—	—
Benin	380	149	136	-13	41	50	-9	—	—	—
Botswana	2590	60	34	-26	66	81	-15	15	15	0
Burkina Faso	350	154	142	-12	29	49	-20	—	—	—
Burundi	210	179	177	-2	57	37	+20	38	31	-7
Cameroon	940	121	74	-47	73	67	+6	17	24	+7
C. Afr. Rep.	390	—	—	—	44	51	-7	—	—	—
Chad	220	—	—	—	45	38	+7	—	—	—
Congo	1210	—	—	—	72	70	+2	24	17	-7
Côte d'Ivoire	690	127	95	-32	58	62	-4	12	20	+8
Ethiopia	120	212	215	+3	17	24	-7	38	39	+1
Gabon	3780	—	—	—	50	85	-35	—	—	—
Ghana	400	170	133	-37	74	51	+23	27	26	-1
Guinea	430	—	—	—	25	54	-29	—	—	—
Guinea-Bissau	190	—	—	—	25	35	-10	23	38	+15
Kenya	340	75	44	+69	71	48	+23	14	28	+14
Lesotho	580	157	107	-50	57	59	-2	16	24	+8
Liberia	450	218	125	-93	—	—	—	20	25	+5
Madagascar	230	173	177	+4	54	57	-3	33	28	-5
Malawi	220	228	171	-57	51	60	-9	24	35	+11
Mali	280	225	158	-67	18	44	-26	31	33	+2
Mauritania	510	209	116	-93	32	56	-17	48	24	-25
Mauritius	2450	25	36	+11	89	81	+9	24	15	-9
Mozambique	70	292	253	-39	65	50	+15	—	—	—
Namibia	1420	91	72	-19	70	70	0	29	16	-13
Niger	300	320	153	-167	23	45	-22	49	32	-17
Nigeria	290	191	155	-36	59	45	+14	36	30	-7
Rwanda	260	222	163	-60	59	42	+17	33	30	-3
Senegal	720	150	92	-58	52	63	-11	22	25	+3
Sierra Leone	210	—	—	—	—	—	—	23	32	+9
Somalia	120	—	—	—	2	24	-22	—	—	—
South Africa	2530	72	34	-38	—	—	—	—	—	—
Tanzania	100	178	228	+50	24	20	+4	48	35	-13
Togo	410	140	131	-9	70	52	+18	24	27	+3
Uganda	160	185	96	+11	—	—	—	23	33	+10
Zaire	220	189	174	-15	59	38	+21	—	—	—
Zambia	420	200	129	-71	61	52	+9	25	26	+1
Zimbabwe	620	98	83	+15	74	40	+34	12	21	+9
MIDDLE EAST and NORTH AFRICA										
Algeria	2020	61	40	-21	95	78	+17	10	9	-1
Egypt	620	72	103	+31	75	60	+15	10	22	+12
Iran	2320	62	37	-26	91	80	+11	43	10	-33
Iraq	1500	143	49	-94	72	74	-2	12	12	0
Jordan	1120	32	62	+30	92	70	+22	6	13	+7
Kuwait	16210	17	11	-6	83	94	-11	6	5	-1
Morocco	1030	66	68	+2	60	69	-9	16	21	+5
Oman	5650	33	21	-12	91	89	+2	—	—	—
Saudi Arabia	7150	43	18	-25	68	91	-23	—	—	—
Sudan	420	169	129	-40	44	52	-8	20	26	+6
Syria	1110	42	63	+21	94	70	+24	—	—	—
Tunisia	1510	42	49	+7	87	74	+13	10	14	+4
Turkey	1820	91	43	-48	97	77	+20	—	—	—
U. Arab Emirates	19860	23	9	-14	97	95	+2	—	—	—
Yemen	540	—	—	—	—	—	—	53	23	-30
SOUTH ASIA										
Afghanistan	280	—	—	—	25	44	-19	—	—	—
Bangladesh	220	133	74	+41	47	38	+9	66	33	-33
Bhutan	180	205	188	-17	12	34	-22	38	35	-4
India	330	126	46	+20	53	47	+6	63	28	-36
Nepal	180	132	188	+56	—	—	—	—	—	—
Pakistan	400	138	133	-5	37	51	-14	40	26	-14
Sri Lanka	500	21	18	+97	91	56	+35	29	25	-4
EAST ASIA and PACIFIC										
China	370	43	38	+95	85	50	+35	21	29	+8
Hong Kong	11200	7	12	+5	99	94	+5	—	—	—
Indonesia	610	111	104	-7	83	60	+23	40	24	-16

ANCE GAPS

	GNP per capita	Under-five mortality rate 1991			% of children reaching grade 5			% of under-five children underweight		
		Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
Korea, Dem	970	34	72	**+38**	—	—	—	—	—	—
Korea, Rep	6340	10	19	**+9**	90	90	**0**	—	—	—
Lao Rep	230	148	171	**+23**	22	40	**-18**	37	22	**-15**
Malaysia	2490	20	35	**+15**	86	81	**+5**	—	—	—
Mongolia	780	82	87	**+5**	—	—	—	—	—	—
Myanmar	220	117	174	**+57**	—	—	—	32	32	**0**
Papua N. Guinea	820	79	83	**+4**	53	65	**-12**	35	20	**-16**
Philippines	740	61	90	**+29**	75	63	**+12**	34	20	**-14**
Singapore	12890	8	12	**+4**	100	94	**+6**	14	8	**-6**
Thailand	1580	35	47	**+12**	63	75	**-12**	26	18	**-8**
Viet Nam	240	52	168	**+116**	—	—	—	42	31	**-11**
CENTRAL AMERICA and CARIBBEAN										
Costa Rica	1930	15	41	**+26**	84	78	**+6**	6	15	**+9**
Cuba	1170	12	59	**+47**	90	71	**+19**	—	—	—
Dominican Rep	950	53	73	**+20**	46	67	**-21**	13	20	**+7**
El Salvador	1070	67	65	**-2**	45	69	**-24**	15	18	**+3**
Guatemala	930	80	74	**-6**	41	67	**-26**	34	17	**-17**
Haiti	370	137	138	**+1**	12	50	**-38**	37	33	**-4**
Honduras	570	60	108	**+48**	48	59	**-11**	21	18	**-3**
Jamaica	1380	15	52	**+37**	96	73	**+23**	7	13	**+6**
Mexico	2870	36	32	**-4**	76	82	**-6**	14	10	**-4**
Nicaragua	340	81	144	**+63**	44	48	**-4**	11	18	**+7**
Panama	2180	20	38	**+18**	82	79	**+3**	16	11	**-5**
Trinidad/Tobago	3620	23	28	**+5**	72	85	**-13**	7	8	**+1**
SOUTH AMERICA										
Argentina	2780	25	33	**+8**	—	—	—	—	—	—
Bolivia	650	122	99	**-23**	60	61	**-1**	13	21	**+8**
Brazil	2920	67	31	**-36**	41	83	**-42**	7	9	**+2**
Chile	2160	20	38	**+18**	75	79	**-4**	3	14	**+11**
Colombia	1280	20	55	**+35**	55	72	**-17**	10	14	**+4**
Ecuador	1020	61	68	**+7**	67	69	**-2**	17	16	**-1**
Paraguay	1210	35	57	**+22**	67	71	**-4**	4	16	**+12**
Peru	1020	69	68	**-1**	—	—	—	13	16	**+3**
Uruguay	2860	22	32	**+10**	96	82	**+14**	7	10	**+3**
Venezuela	2610	25	34	**+9**	—	—	—	6	8	**+2**
INDUSTRIALIZED COUNTRIES										
Australia	16590	10	10	**0**	100	94	**+6**	—	—	—
Austria	20380	9	9	**0**	—	—	—	—	—	—
Belgium	19300	10	9	**-1**	81	95	**-14**	—	—	—
Bulgaria	1840	21	43	**+22**	88	77	**+11**	—	—	—
Canada	21260	8	9	**+1**	96	95	**+1**	—	—	—
Czechoslovakia*	2450	13	35	**+22**	94	81	**+13**	—	—	—
Denmark	23660	9	8	**-1**	98	95	**+3**	—	—	—
Finland	24400	7	8	**+1**	100	95	**+5**	—	—	—
France	20600	9	9	**0**	97	95	**+2**	—	—	—
Germany	23650	9	8	**-1**	98	95	**+3**	—	—	—
Greece	6230	11	20	**+9**	94	90	**+4**	—	—	—
Hungary	2690	17	33	**+16**	94	82	**+12**	—	—	—
Ireland	10780	10	14	**+4**	96	93	**+3**	—	—	—
Israel	11330	12	13	**+1**	94	93	**+1**	—	—	—
Italy	18580	10	10	**0**	89	95	**-6**	—	—	—
Japan	26920	6	7	**+1**	100	96	**+5**	—	—	—
Netherlands	18560	8	10	**+2**	94	95	**-1**	—	—	—
New Zealand	12140	10	13	**+3**	82	93	**-11**	—	—	—
Norway	24160	8	8	**0**	98	95	**+3**	—	—	—
Poland	1830	17	43	**+26**	96	77	**+19**	—	—	—
Portugal	5620	12	21	**+9**	—	—	—	—	—	—
Romania	1340	34	53	**+19**	79	73	**+6**	—	—	—
Spain	12460	9	13	**+4**	97	94	**+3**	—	—	—
Sweden	25490	5	8	**+3**	100	95	**+5**	—	—	—
Switzerland	33510	8	6	**-2**	—	—	—	—	—	—
United Kingdom	16750	9	10	**+1**	—	—	—	—	—	—
USA	22560	11	9	**-3**	96	95	**+1**	—	—	—

* former
Albania, Cambodia, Lebanon and Libya are not included in this table as data are not available except for estimates of per capita GNP.

NATIONAL PERFORMANCE GAPS – DERIVING THE EXPECTED

For each of the three indicators used in these tables, deriving an expected level of performance requires the fitting of a line to country data represented by points on a graph of which one axis is always GNP per capita.

When all countries with data are plotted, the pattern that emerges shows that under-five mortality rates and malnutrition rates generally decrease with increasing GNP, whereas the percentage of children reaching grade 5 generally increases with GNP. For each variable, a line was fitted to match the overall shape of the data points, using a least-squares regression method. GNP data for 1991 were used in plotting the graphs except in the case of underweight children, where the data were matched with GNP data for the same reference year.

The adjusted R-squared for the lines thus drawn varied from a little less than 0.4 in the case of the percentage of children underweight to a little over 0.7 for the under-five mortality rate. Such values show that while there is a general trend linking each variable with GNP, many individual countries diverge considerably from this trend.

It is this lack of conformity with the trend line – the expected level of performance – which yields the national performance gaps for each country. The tables on these pages show national performance gaps in bold type.

REDUCING CHILD

RATES OF PROGRI

Almost all countries have accepted the goal of reducing under-five mortality to 70 per 1000 or less by the year 2000. Where under-five mortality was less than 105 per 1000 in 1990, the goal is a one-third reduction.

Using average annual rates of reduction, these pages compare the rate of progress achieved in the 1980s with the rate of progress needed in the 1990s if the year 2000 goal is to be met.

'On target' denotes those countries where the required rate of progress in the 1990s is lower than the rate achieved in the 1980s. For other countries, the closer to zero, the more likely the target is to be reached.

	Under-five mortality rate (per 1000 live births)			Average annual rate of reduction %		
	1980 actual	1990 actual	2000 goal	1980-1990 actual	1990-2000 required	Difference between actual and required
SUB-SAHARAN AFRICA						
Mauritius	42	26	17	5.0	4.1	on target
Botswana	94	62	41	4.2	4.1	on target
Kenya	112	78	52	3.6	4.1	-0.5
Zimbabwe	125	90	60	3.3	4.1	-0.8
Namibia	114	84	56	3.1	4.1	-1.0
South Africa	91	73	49	2.2	4.1	-1.8
Cameroon	173	125	70	3.2	5.8	-2.6
Côte d'Ivoire	180	130	70	3.3	6.2	-2.9
Senegal	221	155	70	3.5	8.0	-4.5
Burkina Faso	218	159	70	3.1	8.2	-5.1
Togo	175	143	70	2.0	7.1	-5.1
Benin	176	150	70	1.5	7.6	-6.0
Madagascar	216	176	70	2.0	9.2	-7.2
Lesotho	173	158	70	0.9	8.2	-7.3
Tanzania	202	180	70	1.2	9.4	-8.3
Burundi	193	180	70	0.7	9.5	-8.8
Mali	310	230	70	3.0	11.9	-8.9
Zaire	204	190	70	0.7	10.0	-9.3
Ethiopia	260	216	70	1.9	11.2	-9.4
Malawi	290	220	70	2.8	11.9	-9.6
Sierra Leone	249	213	70	1.6	10.1	-9.6
Ghana	167	129	70	2.6	8.9	-9.7
Nigeria	196	191	70	0.2	10.1	-9.8
Uganda	181	185	70	-0.2	9.7	-10.0
Liberia	235	219	70	0.7	11.4	-10.7
Rwanda	222	222	70	0.0	11.5	-11.5
Zambia	160	197	70	-2.1	10.3	-12.4
Niger	320	320	70	0.0	15.2	-15.2
Mozambique	269	297	70	-1.0	14.5	-15.4
MIDDLE EAST and NORTH AFRICA						
Oman	95	35	23	10.0	4.1	on target
United Arab Emirates	64	24	16	9.8	4.1	on target
Egypt	180	76	51	6.6	4.1	on target
Tunisia	102	46	31	7.9	4.1	on target
Algeria	145	67	45	7.6	4.1	on target
Kuwait	35	16	11	7.5	4.1	on target
Morocco	145	72	48	7.0	4.1	on target
Saudi Arabia	90	45	30	6.9	4.1	on target
Iran	126	67	45	6.3	4.1	on target
Jordan	66	35	23	6.4	4.1	on target
Syria	73	44	30	5.0	4.1	on target
Iraq	83	48	32	5.5	4.1	*
Turkey	141	95	63	3.9	4.1	-0.1
Sudan	210	172	70	2.0	9.0	-7.0
SOUTH ASIA						
Sri Lanka	52	23	15	8.2	4.1	on target
Bangladesh	211	140	70	4.1	6.9	-2.8
India	177	131	70	3.0	6.2	-3.2
Nepal	177	135	70	2.7	6.6	-3.9
Pakistan	151	139	70	0.8	6.9	-6.0
Bhutan	249	210	70	1.7	11.0	-9.3
EAST ASIA and PACIFIC						
Malaysia	42	21	14	7.1	4.1	on target
Viet Nam	105	55	37	5.5	4.1	on target
Hong Kong	13	7	5	5.8	4.1	on target
Korea, Rep.	18	10	7	5.3	4.1	on target
Thailand	61	36	24	5.1	4.1	on target
Singapore	13	8	5	4.9	4.1	on target
China	65	43	29	4.1	4.1	on target

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	Under-five mortality rate (per 1000 live births) 1980 actual	1990 actual	2000 goal	Average annual rate of reduction % 1980-1990 actual	1990-2000 required	Difference between actual and required
Mongolia	112	85	56	2.8	4.1	-1.3
Korea, Dem.	43	35	23	2.2	4.1	-1.9
Papua New Guinea	95	80	54	1.7	4.1	-2.3
Philippines	70	62	41	1.2	4.1	-2.9
Indonesia	128	111	70	1.4	4.6	-3.2
Myanmar	146	120	70	2.0	5.4	-3.4
Lao Rep.	190	152	70	2.2	7.8	-5.5
CENTRAL AMERICA AND CARIBBEAN						
Jamaica	39	16	11	8.8	4.1	on target
Mexico	81	39	26	7.3	4.1	on target
Cuba	26	13	9	6.8	4.1	on target
Costa Rica	29	16	11	5.8	4.1	on target
El Salvador	120	70	47	5.4	4.1	on target
Dominican Rep.	94	56	37	5.1	4.1	on target
Nicaragua	143	86	58	5.1	4.1	on target
Trinidad and Tobago	40	24	16	5.1	4.1	on target
Guatemala	136	85	56	4.7	4.1	on target
Honduras	100	62	42	4.7	4.1	on target
Panama	31	21	14	3.9	4.1	-0.1
Haiti	195	140	70	3.3	6.9	-3.6
SOUTH AMERICA						
Colombia	59	21	14	10.2	4.1	on target
Uruguay	42	23	16	5.7	4.1	on target
Peru	130	74	49	5.6	4.1	on target
Chile	35	20	14	5.4	4.1	on target
Paraguay	61	37	25	5.0	4.1	on target
Ecuador	101	63	42	4.7	4.1	on target
Venezuela	42	26	17	4.7	4.1	on target
Argentina	41	26	17	4.6	4.1	on target
Brazil	93	69	46	2.9	4.1	-1.1
Bolivia	170	125	70	3.0	5.8	-2.8
INDUSTRIAL COUNTRIES						
Greece	23	11	7	7.2	4.1	on target
Portugal	31	16	11	6.6	4.1	on target
Austria	17	9	6	6.0	4.1	on target
Germany	16	9	6	5.7	4.1	on target
Italy	17	10	7	5.6	4.1	on target
Spain	16	10	6	5.3	4.1	on target
Japan	11	6	4	5.3	4.1	on target
Israel	19	12	8	5.0	4.1	on target
Hungary	26	16	11	4.7	4.1	on target
Ireland	14	9	6	4.6	4.1	on target
Belgium	15	9	6	4.5	4.1	on target
Czechoslovakia (former)	20	13	9	4.5	4.1	on target
United Kingdom	14	9	6	4.3	4.1	on target
Canada	13	9	6	4.0	4.1	-0.1
Australia	13	10	6	3.4	4.1	-0.6
USA	15	11	7	3.3	4.1	-0.7
Bulgaria	25	18	12	3.2	4.1	-0.8
France	13	9	6	3.3	4.1	-0.8
Poland	24	18	12	2.9	4.1	-1.1
Sweden	9	7	5	2.7	4.1	-1.3
Finland	9	7	5	2.6	4.1	-1.4
Netherlands	11	9	6	2.4	4.1	-1.7
New Zealand	16	12	8	2.3	4.1	-1.8
Switzerland	11	9	6	1.8	4.1	-2.2
Denmark	10	9	6	1.3	4.1	-2.7
Norway	11	10	6	1.0	4.1	-3.1
Romania	36	34	22	0.7	4.1	-3.4

* 1990 estimate preceding the war in the Persian Gulf.

ON TARGET

In total, 52 out of the 112 nations listed here are on target to meet the year 2000 goal provided they maintain the rate of progress they achieved in the 1980s.

In some countries the gap is very wide between the rate of progress achieved in the 1980s and the rate required in the 1990s. In the main, these are countries where under-five mortality is so high that reaching the target of 70 per 1000 implies a much bigger reduction than one third. The eight African countries with under-five mortality rates of more than 200 in 1990, for example, would all require a reduction of two thirds to reach the goal of 70 per 1000.

The figures for under-five mortality given in the league table on pages 8 and 9 are estimates for 1991 and may suggest different rates of progress from the estimates given here, which represent trends calculated across a ten-year span. Single-year rates are likely to fluctuate, especially in less populous countries where a small change in the number of child deaths may have a disproportionate impact on the under-five mortality rate for that year.

All numbers have been rounded for ease of reading. The numbers in the last column reflect calculations made before the rounding.

The 'no data' countries (see pages 8 and 9) are excluded from these tables.

Human development

In recent years, increasing attention has been given to human development and to the evolution of new and better ways of measuring efforts to meet human needs. The United Nations Development Programme publishes the annual *Human development report*, incorporating a human development index; the World Bank publishes the annual *World development report*, which regularly provides estimates of the proportion of the world's people living in poverty. In its 1993 edition, the *World development report* focuses on human health and introduces new methods for measuring and comparing the impact of various health interventions. In 1995 the United Nations will hold the World Summit for Social Development to focus attention on all of these issues and particularly on questions of poverty, unemployment, and social cohesion in different parts of the world. UNICEF hopes that *The Progress of Nations* will contribute to all of these efforts to put human development issues at the centre of development thinking and policy making.

A note on per capita GNP

The estimates of per capita GNP given in this publication are those calculated by the World Bank using the conventional World Bank Atlas method which converts local currencies to US dollars by means of averaged exchange rates.

Alternative estimates based on purchasing-power parity (PPP) are now becoming available. The advantage of the new method of calculation is that it attempts to measure each nation's per capita income in terms of its local purchasing power rather than its value on international financial exchanges. This means that estimates of per capita income reflect the fact that more can be bought with one dollar in the developing world than in Europe or North America. PPP estimates are also less vulnerable to exchange-rate fluctuations.

But PPP assessment is a major undertaking, especially for poor countries, as it entails collecting and correlating a broad range of data on the local pricing of goods and services. So far, this work has been completed in fewer than 70 nations. Estimates for all other countries are, at the moment, based on mathematical models. A further difficulty is that different methods of calculation can yield different figures from the same data. Economists at the University of Pennsylvania, for example, have used the PPP approach and estimated China's 1990 per capita income at approximately $2600, considerably more than the World Bank estimate of $1950 which is itself significantly larger than the International Monetary Fund estimate of $1300. For 20 countries, there is a difference of more than 20% between the 1990 PPP income estimates of the World Bank and those of the United Nations Development Programme.

For the time being, therefore, *The Progress of Nations* employs per capita GNP figures based on the exchange-rate method of conversion.